

# Iowa Department of Human Services



***Innovation Plan***  
**December 2013**

# Table of Contents

Executive Summary.....	1
1. Iowa's Vision for Health System Transformation.....	17
Goals .....	17
Organizing Principles.....	18
Proposed Strategies.....	19
Phased-In Approach.....	24
Stakeholder Engagement.....	26
2. Population Demographics.....	31
Rural and Older Population.....	31
Race and Languages Spoken .....	32
Poverty and Health Insurance Coverage.....	33
Iowa's Children.....	34
Demographics of Medicaid Enrollees .....	35
Demographics of CHIP Enrollees.....	35
Demographics of Medicare Beneficiaries .....	36
3. Population Health Status and Issues or Barriers.....	36
Population Health Status .....	36
Issues and Barriers to Improved Health.....	45
4. Current Health Care Cost Performance Trends and Factors Affecting Cost Trends .....	55
Overall Costs .....	55
Medicaid Costs.....	56
5. Special Needs Populations and Factors Impacting Care, Health and Cost .....	69
Individuals Enrolled in Medicare and Medicaid – “Dual Eligible” Individuals .....	69
People with High Long Term Care Needs.....	72
Individuals with Severe and Persistent Mental Illness or Severe Emotional Disturbance .....	73
Special Populations of Children .....	73
Individuals who are Experiencing Homelessness .....	74
Incarcerated Populations.....	74
Native American Population .....	75

6. Opportunities and Challenges to Adoption for Health Information Exchange (HIE) and Meaningful Use of Electronic Health Record Technologies .....	75
As Is – Iowa’s Current Health Information Landscape.....	76
The Iowa e-Health Initiative.....	76
Fostering Meaningful Use – Iowa’s EHR Incentive Program.....	82
To Be – Expanding and Enhancing the Capacity of Iowa’s Health Care Information Systems to Support Accountable Care .....	90
7. “As Is” of Iowa’s Health Care Delivery System Models and Payment Methods .....	98
Hospital Engagement Network .....	99
Medicaid .....	100
Medicare .....	113
Commercial .....	114
8. “As Is” Current Health Care Delivery System Performance Measures and Factors Affecting Quality .	116
Medicaid Performance.....	117
Medicare Performance .....	118
Commercial Performance .....	119
9. Analysis of Medicaid Practice Patterns.....	123
Medical Neighborhoods and Regions .....	123
Migration of Dollars Across Regions .....	125
Migration of Dollars Out of State.....	126
10. Goals and Strategies for the Delivery System, Payment Structure and Quality Improvement: "To Be State" .....	127
Iowa Health and Wellness Plan.....	128
ACO Model Specifications.....	131
Future Delivery System Payment Methods .....	136
Increased Transparency.....	137
11. Future Status of Factors Impacting Population Health Status.....	138
Provider Support and Ensuring a Sufficient and Appropriate Workforce .....	138
Creation of a Reinvestment Fund .....	143
Governor’s Healthiest State Initiative and the Blue Zones Project.....	144
12. Cost, Quality, and Population Health Performance Targets.....	144
Targets for Reducing Cost.....	148

Targets for Improving Care .....	149
Targets for Improving Satisfaction with Care .....	152
Targets for Improving Health Outcomes .....	152
Iowa's Self-Evaluation .....	159
13. Transformation Timeline and Review of Milestones and Opportunities .....	167
December 30, 2013: SHIP due to CMS.....	167
Winter 2014: Iowa Health and Wellness Plan Implementation and Model Testing Grant Proposal ...	167
Spring/Summer 2014: State Issues Request for Information for Prospective ACOs .....	168
Fall 2014/Winter 2015: State issues Request for Proposals for Prospective ACOs.....	168
Winter/Spring 2015: State Selects Regional ACOs .....	169
January 2016: ACOs Implemented.....	169
January 2017: ACOs Held Accountable for Total Cost of Care.....	169
State Fiscal Year 2020: ACOs are Fully Capitated .....	169
14. Policy, Regulatory and Legislative Changes Necessary .....	170
Appendices.....	174
Appendix A: Acronym List .....	I
Appendix B: Methodology .....	III
Appendix C: Steering Committee Membership .....	VII
Appendix D: Workgroup Members .....	VIII

## Executive Summary

The State of Iowa has developed this State Healthcare Innovation Plan (SHIP) to serve as the guiding structure to develop and implement a new health care payment and delivery system that will reduce health care costs, improve population health and improve patient care. The SHIP builds off other payment and delivery system reform efforts underway in Iowa, including Health Homes, Integrated Health Homes (IHH), the Balancing Incentives Payment Program (BIPP), the Iowa Health and Wellness Plan, and the Mental Health and Disability Services (MHDS) Redesign. All of these initiatives align with the State Innovation Model (SIM) which is providing the State with an opportunity to transform the health care system across the State.

The Iowa Medicaid Enterprise (IME) in the Department of Human Services (DHS) has taken a lead role in the development of the SHIP. This SHIP is organized into the following sections.

### Section 1: Iowa's Vision for Health System Transformation

This section provides an overview of the articulated goals, organizing principles and strategies the State has used throughout the early SIM process, and will continue to use. Early in the SIM process, the State articulated what a successfully transformed system looks like. This vision was developed by the State and shared with workgroup members for their feedback and is as follows:

The new, transformed health care system will be a patient-centered, value-based delivery system that makes Iowans healthier, and supports Iowans in actively participating in their care, for both maintenance and improvement of their health. As part of the transformation, consistent and transparent standards and measures will be adopted that allow for demonstration of these improvements and the impacts of these improvements on Iowans' health.

The State's primary goal is to achieve the Triple Aim of: (1) reducing the per capita cost of health care; (2) improving the health of populations; and (3) improving the patient experience of care (including quality and satisfaction). The other goals are to:

1. Create a system that supports and encourages Iowans to participate in their own care;
2. Encourage and support stakeholder participation in the process to transform Iowa's health care system;
3. Utilize available funding opportunities to maximize the success of Iowa's health information exchange, the Iowa Health Information Network, enabling patients to access their personal health information and allowing Iowa providers to exchange electronic health information; and
4. Reduce health care costs for all of Iowa. Preliminary analyses conducted by Milliman, Inc., suggest that the proposed Medicaid Accountable Care

Organization (ACO) model has the potential to result in a 5% reduction in costs. The State anticipates that, with the inclusion of Medicare data in the analysis and expansion of ACOs, there could be additional savings.

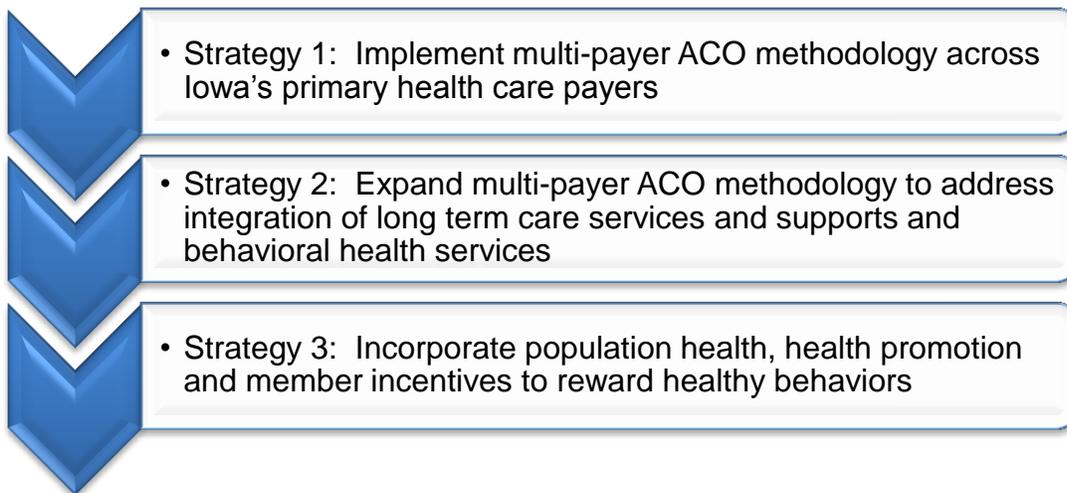
To achieve these goals there will be:

1. Dedicated and consistent leadership within all sectors including: public purchasers, private purchasers, providers, consumers, trade groups and associations, public health, research and policy organizations and other government entities.
2. Collaboration and open communication
3. Clarity in accountability
4. System transparency
5. Alignment in measures and analytics

These principles are addressed throughout this SHIP, and are reflected in the strategies and levers the State will use to transform Iowa's health care system. This vision, these goals, and the organizing principles will drive the implementation of the SHIP.

The following strategies were introduced in the State's SIM Design grant application and have been developed further over the past eight months. These strategies will transform Iowa's health care system and help the State achieve its goals for this transformed system.

### Strategies for Iowa's State Innovation Model



Transforming the health care system from one that is primarily unmanaged care provided in a siloed, fee-for-service, volume-based purchasing environment to a system that is value-based, accountable, integrated, and in which data are standardized is an enormous undertaking. To ensure success, the State will implement the SIM work in the following phases:

- Phase 1 is the implementation of the Wellness Plan in January 2014.

- Phase 2 is the implementation of regional ACOs statewide in early 2016. In Phase 2, ACOs will be accountable for total cost of care (TCOC) and quality measures for lowans, but behavioral health and long term care supports and services (LTCSS) will not be included in their accountability
- Phase 3 will expand the level of ACO accountability. In Phase 3a, the ACOs will begin to be accountable for behavioral health services and costs, starting in early 2017. Phase 3b is scheduled for early 2018, when ACOs will be accountable for long term care supports and services.

### SIM Phases and Triggers

Proposed Triggers and Timing for Increasing Total Cost of Care (TCOC) Accountability			
Phase 1 – Wellness Plan ACOs <i>Start 1/1/2014</i>	Phase 2 – Regional Medicaid ACOs <i>Start Early 2016</i>	Phase 3.a. – Behavioral Health Services in TCOC <i>Start Early 2017</i>	Phase 3.b. – LTCSS in TCOC <i>Start Early 2018</i>
<b>Proposed readiness requirements for ACO receiving increased shared savings</b>			
	Trigger: ACO Proposals show readiness	Trigger: ACOs VIS measures around BH show readiness to coordinate these services	Trigger: ACOs VIS measures around LTCSS show readiness to coordinate these services
<ul style="list-style-type: none"> <li>Wellness Plan members have access to primary care</li> <li>Member outreach and engagement strategies</li> <li>Incentives align with members' health behaviors</li> <li>Incentives for system improvement through Value Index Score (VIS) quality measurements</li> <li>No shared savings or downside risk initially (will be added in subsequent years)</li> </ul>	<ul style="list-style-type: none"> <li>Well defined care coordination program</li> <li>Community relationships with traditional and non-traditional providers established</li> <li>ACO payment structure</li> <li>Shared savings triggered by VIS and TCOC outcomes</li> <li>ACOs choice:3 risk levels</li> <li>Up and down side risk</li> <li>Some BH and some LTCSS expenditures not included in TCOC calculation</li> </ul>	<ul style="list-style-type: none"> <li>Established IHH capacity to serve Serious &amp; Persistent Mental Ill (SPMI) population</li> <li>Established formal relationships with IHH providers</li> <li>Refined care coordination program to account for complexities of population with high Behavioral Health needs</li> </ul>	<ul style="list-style-type: none"> <li>Established formal relationships with all Long Term Care (LTC) provider types, including but not limited to those serving individuals with Intellectual Disabilities</li> <li>Demonstrates data sharing capabilities with LTC providers</li> <li>Demonstrated Balancing Incentive Payment Program (BIPP) with increased percentage of home and community based (HCBS) spending</li> <li>Refined care coordination program to account for complexities of populations</li> </ul>

## Section 2: Population Demographics

Section 2 provides an overview of the demographics of lowans, including the age of the population, race and ethnicity, poverty rates, and insurance rates of lowans. The data show that relative to the national average, lowans are:

- Older;
- More likely to live in rural areas;
- Less likely to live in poverty; and
- Less likely to be uninsured.

There are also fewer individuals identifying themselves as black, Hispanic, or a race other than white. As a result, the State has focused less attention and resources on ensuring care is available and provided in multiple languages and in the culture in which patients are most comfortable. This will be a growing need in the future as there was an 84% increase in the number of individuals identifying themselves as Hispanic between 2000 and 2010. The younger population is far more diverse than the older population meaning the State and its ACO partners will need to develop a more comprehensive approach to ensuring people are able to communicate with their providers and receive care in a comfortable and culturally-sensitive manner.

## Section 3: Population Health Status and Issues or Barriers

This section provides an overview of the population health status, and issues and barriers to improving the health of lowans. Generally, residents of Iowa are healthier than those in other states and they report lower rates of fair or poor health status, prevalence of chronic conditions, and obesity rates. Their rates of exercise and tobacco use are similar to the national averages. The State also receives high rankings for quality of health care, although fewer lowans report that they access preventive services. While many of these ratings are relatively high, the aggregate ratings do not provide a complete picture, because there are large disparities across the State and between different populations. Notably, the smoking rate for black men exceeded the rate for all other groups; and there are high rates of binge drinking among younger adults of all races. Moreover, as participation in unhealthy behaviors and prevalence of chronic conditions are higher among racial and ethnic minorities and as that population increases as a percentage of the total population the rates may also increase. As the population demographics change, lack of exercise, obesity, and poor health status rates may increase.

In general, the health of Iowa's children is very good, though there are health and social disparities that exist for children. Black children are more likely to have special healthcare needs than are white children and they are also more likely to report unmet needs for care. There are also geographic disparities. For example, the rates of women who did not receive prenatal care in the first trimester ranges from 15% in some counties to nearly 50% in others.

The barriers to improved health include challenges related to providing care in a primarily rural state, shortages and unequal distribution of providers, and low reimbursement rates for providers. Seventy-nine of the 99 counties have a rural designation and there is no large city in Iowa (only Des Moines has more than 200,000 residents). Attracting and retaining health care providers, including physicians, dentists, nurses, behavioral health workers, and direct care workers is very difficult, particularly in under-served areas, many of which are rural. Surrounding states pay higher rates for most health care services, so many of those who are trained in Iowa leave the State.

It is estimated that about 4.9% of Iowans have a serious and persistent mental illness (SPMI), a slightly higher rate than the national average of 4.6%. However, a lower percent of Iowans (30.6%) report having poor mental health, relative to the U.S. average of 35.8%. Sixty-one counties identified mental health needs as a concern and 25 reported that access to mental health services is an issue. According to the Governor's Healthy Iowans 2010 report, the incidence of Serious Emotional Disturbances among children is 10-12%, a rate that is very similar to the national rate.

#### **Section 4: Current Health Care Cost Performance Trends and Factors Affecting Cost Trends**

In this Section, the narrative describes the current health care cost trends and factors that are affecting those trends. For the most part, health insurance costs for the private market are slightly lower than the costs nationally. However, once those dollar amounts are adjusted for cost of living, the costs are very similar to the national average costs. For Medicaid, the costs per enrollee are quite a bit lower than they are nationally, except that the costs for those with disabilities are about \$3,000 more per year and expenditure per enrollee 65 and older are also higher. Medicaid costs continue to increase each year though the percent change is decreasing. Enrollment in Medicaid continues to increase, though at much smaller rates. As with health care nationally, a small percentage of individuals accounts for a large percentage of expenditures. This is less so for individuals receiving Long Term Care Supports and Services (LTCSS) since there are few non-users in this cohort. In the commercial market, health insurance rates have been increasing; insurance carriers' perception is that inpatient hospital services is the primary driver of cost increases.

Iowa is pursuing a statewide Medicaid ACO model. While there will be ACOs available statewide, Iowa intends to divide the State into several regions based on naturally occurring medical neighborhoods. As of the time of the submission of this SHIP, analysis suggests six naturally occurring regions. To support the State in drafting contracts with the ACOs (following a competitive procurement process) and identifying areas of opportunities and challenges across the State, further analysis of the costs, utilization and out-migration of dollars was conducted for each of these six proposed regions. In this section, the data provide insight into these geographic disparities and demonstrate that some regions have higher costs of care than expected, others have higher than expected rates of potentially preventable events (PPE) and still others have more people that seek care outside of the State. In sum, there are regional differences

and identifying these will help the ACOs identify areas of need and develop interventions that target the key needs in their regions.

## **Section 5: Special Needs Populations and Factors Impacting Care, Health and Cost**

As described in earlier sections, the overall health and well-being of Iowans is quite good relative to that of residents in other states. There are, however, racial, socio-economic and geographic variations and there are some populations that have special and unique needs. In this section of the SHIP information is presented on individuals enrolled in Medicare and Medicaid; those with long term care needs; those with high behavioral health needs (adults with severe mental illness and children with serious emotional disturbance); children, including those with and without special health care needs; individuals experiencing homelessness; those with criminal justice involvement; and Native American populations. As the population of Iowa ages, there will be more residents with extensive health and care needs and there will also be a far more diverse child and youth population. Both of these changes will require the ACOs and the State to think creatively about how to meet the needs of an aging population while concurrently changing the current health care delivery system from a system that serves primarily individuals who are white and speak English to a system that serves a much greater percentage of Hispanic children, some of whom are still learning English.

The Medicaid program will also be experiencing changes in the population served with the Iowa Health and Wellness Plan. While many of those who are eligible will be young and healthy, there will also be a significant number of individuals who are sick, have multiple chronic health conditions (including serious mental illness and substance use challenges) and have gone without treatment for years due to lack of insurance. Many will also be experiencing homelessness or have experienced homelessness and/or have a history of criminal justice involvement.

## **Section 6: Opportunities and Challenges to Adoption for Health Information Exchange (HIE) and Meaningful Use of Electronic Health Record Technologies**

Iowa's reform goals and strategies recognize that accountable care systems require robust information system capacity. Individual providers, health care organizations, and the state must each have the capacity to collect, analyze and share information for various purposes related to their respective roles in the implementation of accountable care. For providers, information systems must support care planning and coordination of care, including use of a comprehensive patient record and standard set of data, patient registries, care planning alerts, and other population health tools to plan and monitor patients' care. Data analytics must help both providers and ACOs to understand the mix of patient acuity, service quality and costs, and performance against benchmark metrics. The state needs the capacity to consistently collect and analyze standardized data in order to successfully implement value-based payment reforms involving Iowa

public and private payers, ACOs, and providers, and to monitor and improve population health.

Iowa's SHIP calls for building on the well-established, multi-faceted Iowa e-Health initiative that began in 2008 and is currently promoting statewide Health Information Technology (HIT) adoption and Health Information Exchange (HIE) development. Iowa's e-Health infrastructure and accomplishments to date reflect active engagement across sectors, involvement of the IME (Iowa Medicaid Enterprise), and sustained leadership and administrative support by the IDPH for development of the Iowa Health Information Network (IHIN). Like other states, Iowa faces challenges to address current barriers to the adoption of HIT and HIE to support accountable care delivery and payment systems.

In this section, there is information about the current Iowa e-Health initiative, including the statewide goals, planning and resources; the strategic and operational plan for HIT adoption and HIE; information on the HIT/HIE capacity as well as prevalence of EHR products among hospitals, provider practices and clinics.

The section also includes detail about the current ("as is") state of meaningful use of electronic health records (EHR), Medicaid EHR incentives, IHIN and the Strategic and Operational Plan. The section ends with information about the future "to be" state, and the approach to continuing to build incrementally upon its strong eHealth foundation for stakeholder engagement, collaborative planning and policy provisions fostering HIT adoption and HIE development. Emphasis will be placed on HIE development efforts to enhance information system support for accountable care.

## **Section 7: "As Is" of Iowa's Health Care Delivery System Models and Payment Methods**

This section provides information about Iowa's existing healthcare delivery system and payment methods. Iowa's healthcare system has many strengths. These strengths include:

- Low rates of uninsured;
- Preventable hospital admissions and avoidable use of the emergency room rates that are lower than the national average;
- Higher medication compliance rates; and
- A culture of innovation and collaboration.

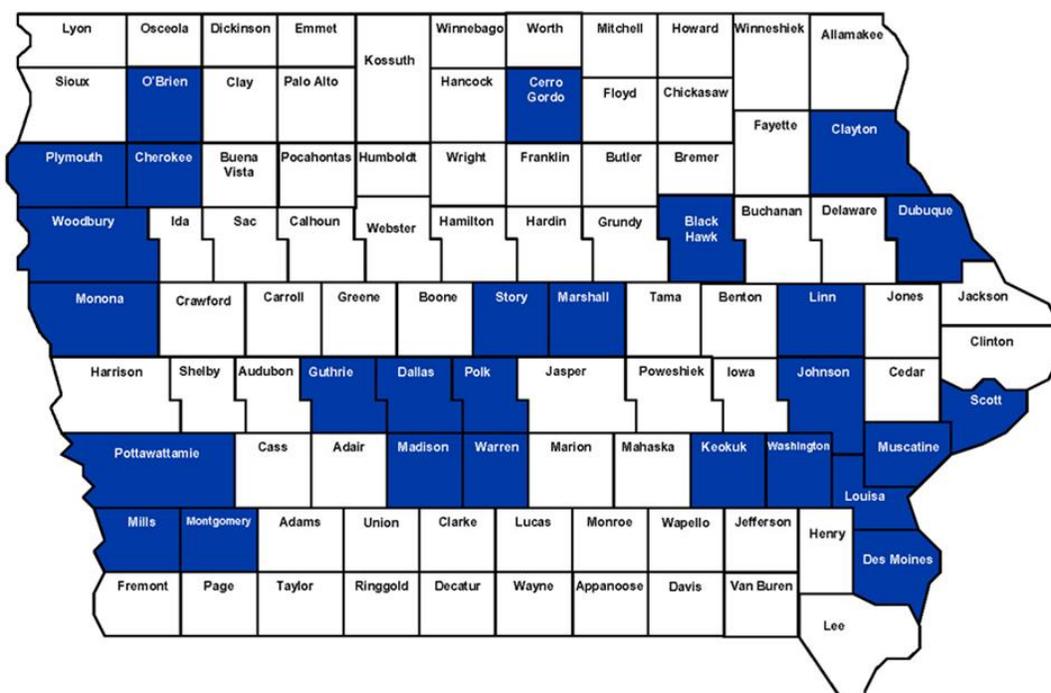
There are also many opportunities to improve upon the health of Iowans, the delivery of care, patient satisfaction with care, and the efficiency of care. These opportunities include an over-reliance on reimbursement methodologies that create perverse incentives and encourage high volumes of services rather than high-value services, and a siloed delivery system that does not support Iowa's history of collaboration and desire to make changes.

Iowa's health care system is characterized by a relatively small number of large entities that already work together. These are very large integrated health systems that deliver the majority of acute care services and employ more than half of the primary care physicians in the State, and a primary payer, Wellmark. Together Wellmark, Medicaid and Medicare cover about 86% of Iowans. This creates a powerful opportunity to develop a more coordinated, accountable and responsive health care system.

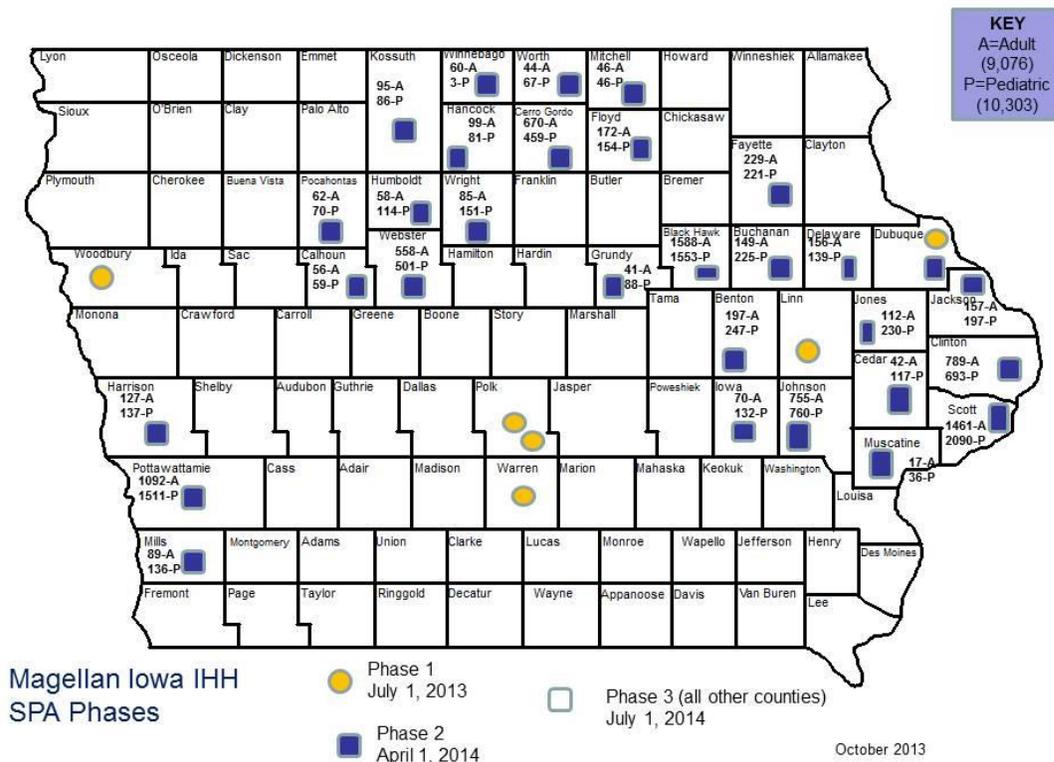
Iowa's Medicaid program is fairly traditional: most enrollees are in a fee for service (FFS) or managed FFS system for their physical health care and there is a capitated managed care option in some counties. Behavioral health services are "carved-out" and a statewide behavioral health organization provides benefits under a full-risk capitated arrangement. There are several home and community based services (HCBS) waiver programs, but there is still relatively high use of institutional care.

Like several other states, Iowa has taken advantage of federal initiatives such as the Balancing Incentive Payment Program (BIPP) and Section 2703 health home opportunities (one of which is targeted for enrollees with Serious Mental Illness or Severe Emotional Disturbance).

### Counties with Health Homes



## Integrated Health Home Sites



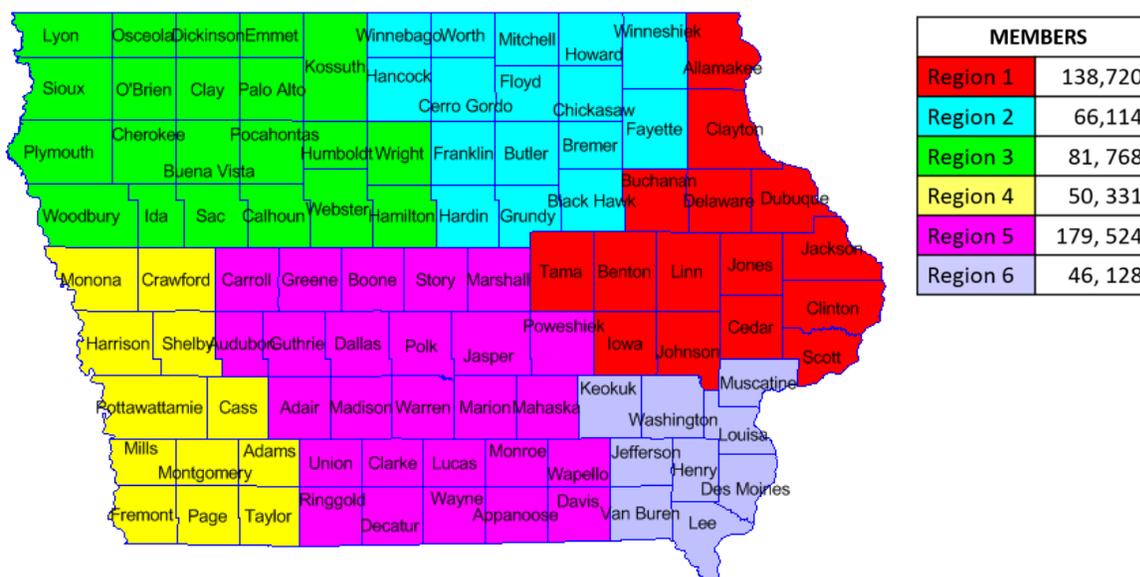
The State is also in the midst of a comprehensive mental health and disability redesign to make this system more consistent across the State, is working with providers to improve their capacity to coordinate care, and is encouraging systems of greater accountability and member engagement through the Iowa Health and Wellness Plan – Iowa's newly approved expansion for those below 133% FPL. These initiatives are aligned with the SIM work and are components of a strong foundation of innovation and collaboration.

The other two primary payers, Wellmark and Medicare, are also changing the way they purchase health care services and there are both Wellmark and Medicare ACOs operating in the State. Enrollment in both is growing. Wellmark has more enrollees and covers a large geographic area:

- 79% of the Medicaid population is in a county with at least one commercial ACO; and
- 85% of the Iowa Health and Wellness Population lives in a county with at least one commercial ACO.

For the Medicaid ACOs (Strategy 1), the IME has proposed a regional approach. Based on analysis of Medicaid claims data, there appear to be several medical neighborhoods which were used to develop six regions.

## Proposed Regions



As of the time of submission of this SHIP, five of the six proposed regions have at least one ACO operating within its boundaries and three of the regions have more than one ACO. These ACOs all have payment methodologies that incentivize accountability for total cost of care and provision of high-value health care services. Wellmark is using the same approach to measuring performance, the Treo Value Index Score (VIS),<sup>TM</sup> that the State will use for its Medicaid ACOs.

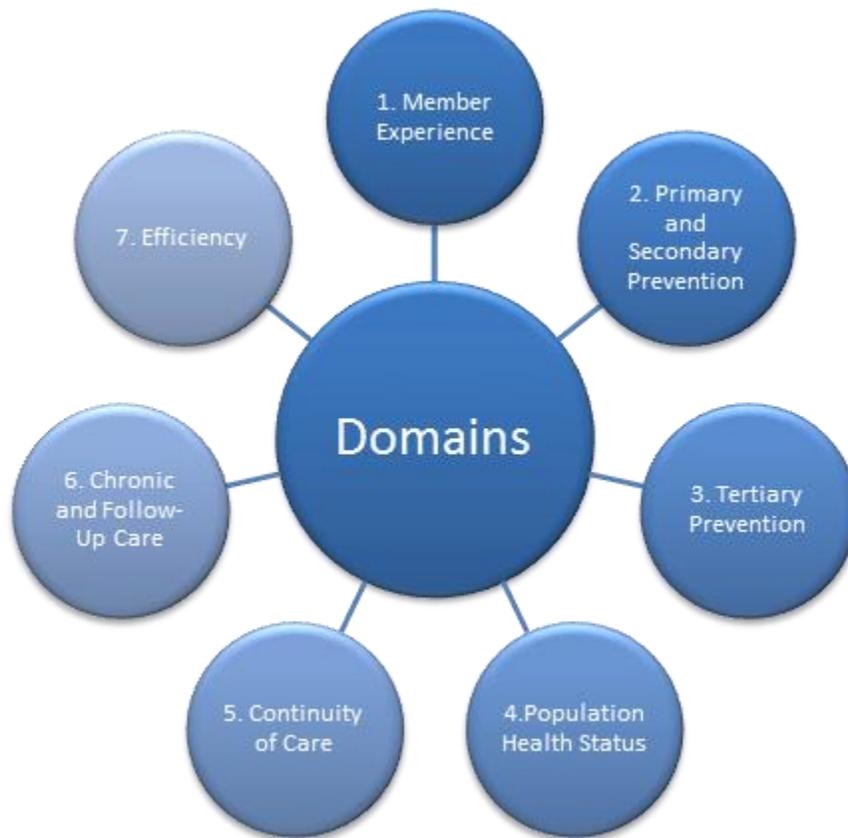
## Section 8: Current Health Care Delivery System Performance Measures and Factors Affecting quality

Overall, Iowa performs well relative to other states on key indicators such as avoidable ER visits, preventable hospitalizations, 30-day readmission rates for Medicare beneficiaries, and health care costs. However, the rates are generally within several percentage points of national averages and there is a large gap between Iowa's rate and the rates of the highest performing states. There is definitely room for improvement.

The State monitors Medicaid quality activities with frequently used tools such as HEDIS and Consumer Assessment of Health Plan Study (CAHPS) as well as use of additional questions about access to care. University and research partners evaluate the programs and there are requirements for quality improvement programs and internal quality assurance systems in accordance with federal regulations. LTCSS providers are monitored to ensure the health and safety of their patients and the State monitors complaints and grievances. Until the implementation of the Medicare ACOs, quality metrics were standard Medicare metrics.

With the transition to ACOs, the level of accountability for quality and improved health has increased. Both Medicare and Wellmark hold the ACOs to specific targets and thresholds and provide financial incentives for providing high-value health care in multiple domains. The State will use the Wellmark value measurement system – the VIS

– which will align the goals of Medicaid and Wellmark. There are seven domains in the VIS:



## Section 9: Analysis of Medicaid Practice Patterns

The State has been committed to using data to drive decisions about regions, priorities, payment approaches and contracting requirements. To ensure the development of a "data-driven SHIP" SIM monies have been used to support significant analyses of Medicaid claims data. In Section 9, there is a discussion of the findings of this comprehensive look at Medicaid cost and utilization using the six proposed regions. The analyses were conducted to understand practice patterns and to make program design decisions that address any identified areas of opportunity for savings, improved care and, ultimately, improved health of Iowans.

The first step was to examine practice referral patterns to identify medical neighborhoods that exist currently. From these patterns, it was evident there were six naturally-occurring neighborhoods; final regions were derived by drawing hard lines at the county level around these neighborhoods which had been built at the zip code level. The final regional map appears in the previous section of this Executive Summary.

Using these regions, the State analyzed the migration of dollars across regions and the percentage of dollars that leave the State to determine how tight these referral patterns are and to assess areas of opportunity and need.

## **Section 10: Goals and Strategies for the Delivery System, Payment Structure and Quality Improvement: "To Be State"**

In this section there is additional information about the Iowa Health and Wellness Plan, since the implementation of this new program is Phase I of the transition to ACOs. The Iowa Health and Wellness Plan will incorporate and build upon the ACO structure in place with Wellmark, and will support medical homes. The State has aligned the financial incentives for providers with those for enrollees – for example, enrollees get rewarded for receiving a health assessment and providers can receive financial bonuses if a pre-determined percentage of their attributed patients receive a health assessment. The State will evaluate the strategies of the Iowa Health and Wellness plan to assess whether they will be effective as part of the statewide Medicaid ACO model.

Section 10 also provides more concrete descriptions of the ACO model specifications and future delivery system payment methods. The ACO model provides an opportunity to transform Iowa Medicaid into a patient-centered system that provides coordinated and integrated care, improves the patient experience of care, achieves better outcomes, aligns Medicaid with other payers, and reduces costs. During the stakeholder meetings and workgroup sessions there were many discussions about the preferred contracting approach and many of the recommendations reflect priorities of the workgroup members.

In the "Contracting and Regions" and "Provider Relationships" sections there is discussion of :

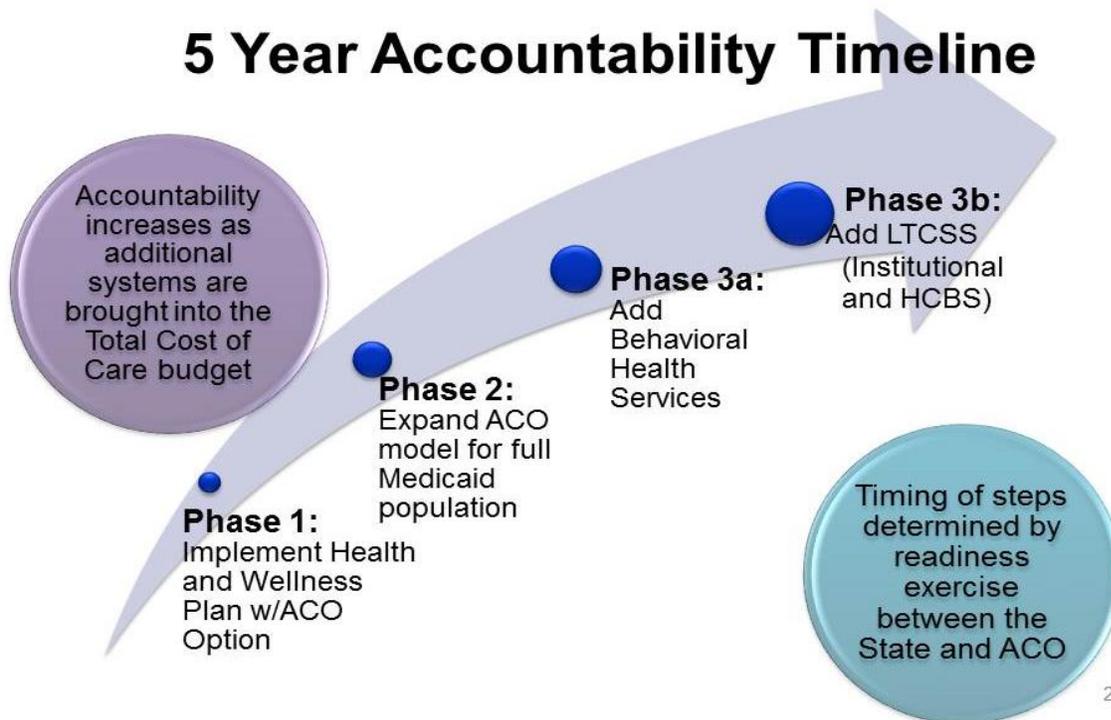
- The use of a competitive procurement process to award ACOs based on the six naturally-occurring regions.
- The advantages of a regional approach which will ensure sufficient volume and scale for an ACO to effectively provide population management and accept risk; accountability state-wide for both rural and urban areas; and that each ACO will capitalize on the strengths of community each community.
- Openness of the State to contracting with any organizational/business structure including managed care organizations and collaborations between provider groups or safety net providers.
- State requirements that ACOs develop strong relationships and collaborate with quality partners in their region to enhance care coordination, reduce costs, ensure access and change the overall health care system to one focused on outcomes. Through these partnerships, the ACO will build upon local and community agencies' strengths and expertise and will be permitted and encouraged to identify strong partners. Stakeholders agreed that the State should not specify groups or entities with whom the ACO must contract and preferred that the State establish clear

expectations for performance and permit the ACOs to develop relationships and partnerships that will be most beneficial.

One of the primary goals is to ensure accountability and alignment of the Medicaid ACOs with other payers. The State will encourage all payers to adopt a core set of measures and will use the VIS measures as a foundation. Because Medicaid enrollees have higher needs for behavioral health services and LTCSS, the VIS will be augmented with additional measures. The specific measures have not been decided upon and the State will continue to work with stakeholders to select these new measures. The State will also develop measures that will ensure the health improvement focus is also on children – which will result in longer-term savings – and not just those lowans with high costs and high needs (where there is greater likelihood of short-term savings and health improvements). Similar to the approach to pediatric measures, the State will work with stakeholders to explore ways to hold the ACOs accountable for the non-health care factors that contribute to poor health and well-being. This will be essential to meeting the Governor's objective to make Iowa the healthiest state.

The State will eventually hold the ACOs accountable for the total cost of care for all enrollees for all services. This is the cornerstone to any shared savings methodology. Methodologies will be risk-adjusted and transparent. The new payments will be phased in starting with all medical services, and then adding in behavioral health services and then LTCSS. The intention is to give the State, the providers and Medicaid enrollees the opportunity to learn how to establish solid relationships and partnerships and incentivize members to be active participants in their health. There will be triggers and target dates for the addition of more services into the total cost of care calculations.

## 5 Year Accountability Timeline



2

The success of this type of accountability is incumbent upon a transparent data and sharing process. The State will develop standard analytics and a model of distribution that provides the ACOs and their providers with access to the key metrics to which they are being held accountable as well as to patient level detail that is actionable.

## **Section 11: Future Status of Factors Impacting Population Health Status**

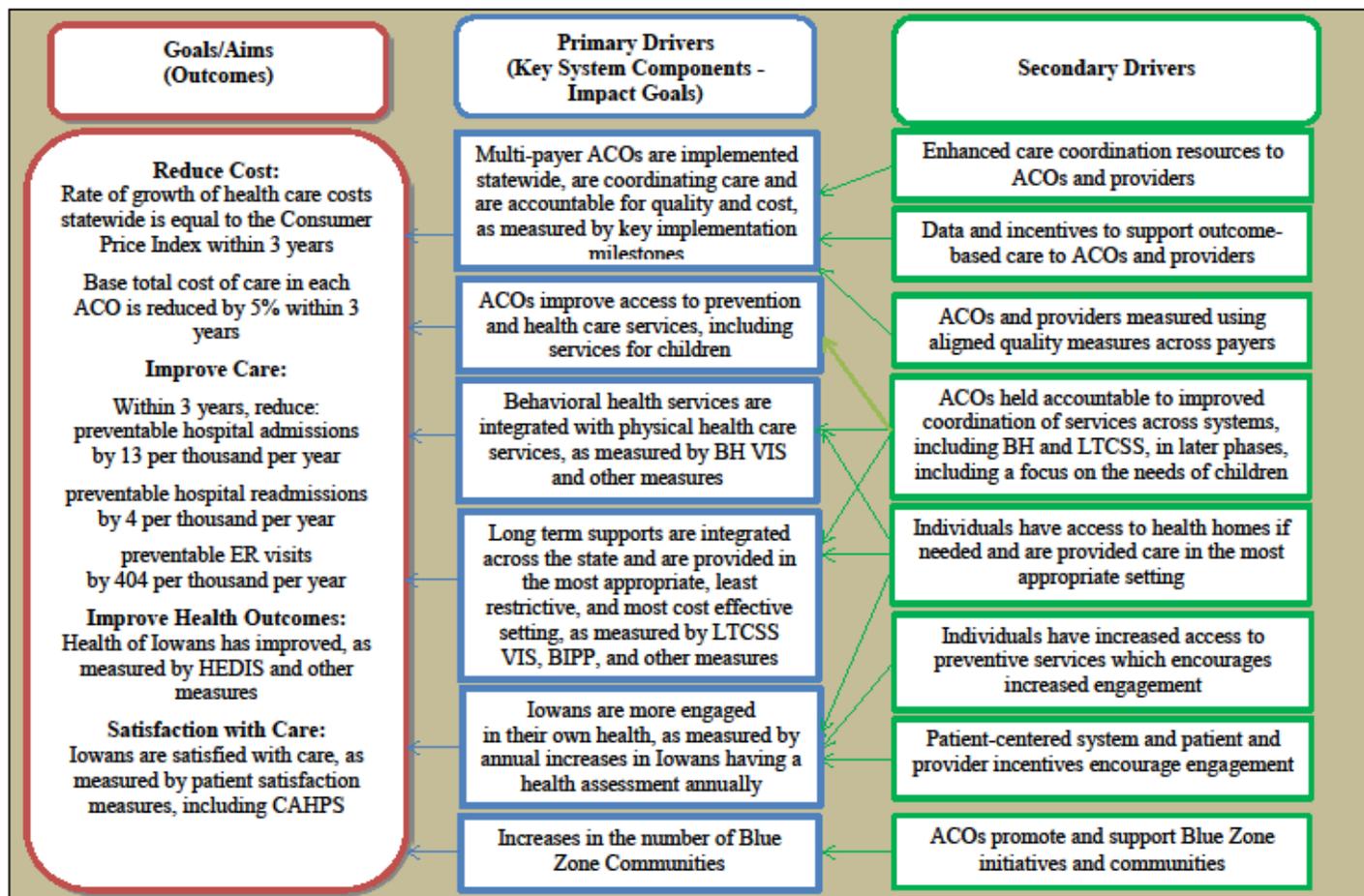
At nearly all stakeholder meetings and workgroup sessions at least one person mentioned the provider shortages around the State (particularly in rural areas and for behavioral health and direct care providers) as well as the need to train and educate providers about the new delivery and payment system and the shift in focus to a more collaborative, coordinated, accountable system. Many people also mentioned the need to support and incentivize enrollees in becoming more engaged in their health and health care. To address these issues, the State proposes to:

- Provide a forum for technical assistance and support for system transformation and encourage learning across ACOs;
- Build on the multiple initiatives already underway to address workforce challenges, including loan repayment programs. The IME will collaborate with the Iowa Health Workforce Center to help implement the recommendations from the Health and Long-Term Care Workforce Summit and support those recommendations that have been implemented;
- Consider a financing mechanism to support longer-term investments in improved healthcare delivery by, for example, ensuring the health and proper development of children; and
- Work with the ACOs to develop and implement plans that will encourage the people they serve to engage in prevention-related activities;
- Align the incentives and the metrics for ACOs with incentives for members who actively participate in becoming, and staying, healthy; and
- Hold the ACOs accountable for innovative, in-depth member education and outreach to ensure members have the tools and information to be better consumers of health care services.

## **Section 12: Cost, Quality and Population Health Performance Targets**

This section provides an overview of the measurable goals and aims of the SIM work, including an overview of the primary and secondary drivers that will be utilized to achieve these aims, and the measures that will be used to track and monitor progress toward the goals. The section begins with a “driver diagram” that illustrates these goals and measures in a visual format. The section then provides details about each driver, measure and goal.

## Iowa's SIM Driver Diagram



While not every measure has been finalized, the State has determined that it will use a set of measures that are already being utilized within the Wellmark ACOs, and that are in alignment with both Centers for Medicare and Medicaid Innovations (CMMI) priorities and measures and with other national measures.

The VIS core measures will be used to track ACO progress and in any shared payment strategies. The VIS includes measures of: Member Experience, Primary and Secondary Prevention, Tertiary Prevention, Chronic and Follow-Up Care, Continuity of Care, Population Health Status, and Efficiency. Many of these measures align with National Quality Forum measures and the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Additional measures are under consideration for measuring both ACO progress and statewide population health, including measures of tobacco use and cessation, obesity, mental health, and measures related to children's health. Both health

outcome measures and measures of access to and utilization of preventive services are being considered in all of these areas. There is a table of key measures that will be used, or that are being explored for inclusion and use.

Additionally, this section provides an overview of key implementation milestones, and goals that must be achieved in order to progress to the next phase of SIM implementation. Last, this section provides an overview of possible payment methods that may be used under the new SIM model.

### **Section 13: Transformation Timeline and Review of Milestones and Opportunities**

This section provides a high-level timeline of activities that will ensure the activities and innovations that have been developed over the past year (including the time prior to award of the SIM grant) and are outlined in this SHIP will be implemented. These dates will continue to be refined and finalized.

### **Section 14: Policy, Regulatory and Legislative Changes Necessary**

The final section summarizes the State's initial thoughts as to legislative and regulatory changes as well as federal approvals required. As a result of the Iowa Health and Wellness Plan, many of the legislative changes have been made. Moreover, the State is already working on regulatory changes. At this point, the State intends to monitor the Iowa Health and Wellness Plan to assess whether additional legislation or rule changes are required.

Regarding federal approval, the State intends to collaborate closely with CMS to determine the type of federal authority that will enable the State and CMS to meet their goals and objectives. To ensure federal approval is received in time to implement the ACO model, the State intends to continue to dialogue with CMS and to build upon the relationships established over the past several months to obtain federal approval of the 1115 Demonstration Waiver for the Iowa Health and Wellness Plan.

## 1. Iowa's Vision for Health System Transformation (Responds to Question 1)

Iowa has demonstrated dedication to creating innovative health options. At the time of submission of this State Healthcare Innovation Plan (SHIP), Iowa (the “State”) is in the midst of multiple payment and delivery system reform efforts, including Health Homes, Integrated Health Homes (IHH), the Balancing Incentives Payment Program (BIPP), and the Mental Health and Disability Services (MHDS) Redesign. The State is also developing and implementing an Iowa-specific approach to covering the Accountable Care Act (ACA) Medicaid expansion group. All of these initiatives align with the State Innovation Model (SIM) which is providing the State with an opportunity to transform the health care system across the State. The Iowa Medicaid Enterprise (IME) in the Department of Human Services (DHS) has taken a lead role in the development of the SHIP.

Early in the SIM process, the State articulated what a successfully transformed system looks like. This vision was developed by the State and shared with workgroup members for their feedback and is as follows:

The new, transformed health care system will be a patient-centered, value-based delivery system that makes Iowans healthier, and supports Iowans in actively participating in their care, for both maintenance and improvement of their health. As part of the transformation, consistent and transparent standards and measures will be adopted that allow for demonstration of these improvements and the impacts of these improvements on Iowans’ health.

The following are the primary goals and organizing principles of this transformation.

### Goals

Like many other states, private payers, and the federal government, Iowa’s primary goal for health care is to achieve the Triple Aim as developed by the Institute for Healthcare Improvement. There are three main concepts of the Triple Aim: (1) reducing the per capita cost of health care; (2) improving the health of populations; and (3) improving the patient experience of care (including quality and satisfaction) have been articulated as the first goal of the Iowa SIM. The other goals are to:

1. Create a system that supports and encourages Iowans to participate in their own care;
2. Encourage and support stakeholder participation in the process to transform Iowa's health care system into one that achieves the Triple Aim and supports Iowans in participating in their own care and in achieving improved health;
3. Utilize available funding opportunities to maximize the success of Iowa’s health information exchange, the Iowa Health Information Network, enabling patients to access their personal health information and allowing Iowa providers to exchange electronic health information; and

4. Reduce health care costs for all of Iowa. Preliminary analyses conducted by Milliman, Inc., suggest that the proposed Medicaid Accountable Care Organization (ACO) model has the potential to result in a 5% reduction in costs over four years. Because these preliminary analyses did not include Medicare data, there may be an opportunity for greater cost savings to the State. As ACO activity continues to grow and expand, it is anticipated that there will be even more efficiencies realized within the overall system. As the ACO model develops, additional analyses will be conducted to determine how additional cost savings may be possible.

## Organizing Principles

Iowa envisions a system that will have:

6. Dedicated and consistent leadership within all sectors including: public purchasers, private purchasers, providers, consumers, trade groups and associations, public health, research and policy organizations and other government entities.
7. Collaboration and open communication
  - a. System participants regularly engage with each other to share best practices.
  - b. Iowa Medicaid Enterprise (IME), health plans, purchasers, systems, providers, consumers and other government agencies meet and collaborate regularly; there are established forums for this communication. Attendees include those who have not participated historically but are important stakeholders.
  - c. Information sharing and communications are supported by dependable and secure connectivity among providers.
  - d. Legacy barriers between and across behavioral health, physical health, long term care supports and services and public health agencies have been broken down.
8. Clarity in accountability
  - a. All Iowans have a true medical home which is accountable for them.
  - b. There are established rules for how to accommodate shifts in accountability (e.g. movements from community dwelling to institutions; new diagnosis as severe and persistent mental illness (SPMI)).
  - c. There are established rules for accountability in situations with multiple care managers and care coordinators.
  - d. Patients recognize the system as easy to access and convenient, they take personal responsibility to get well and stay well, and they understand who is accountable for helping them do this.
    - i. Patients are appropriately informed and equipped to self-direct, participate and collaborate in their health care in all situations.
    - ii. Every patient identifies with a primary care office as their “medical home.”
    - iii. Every patient can provide input to providers and plans easily.

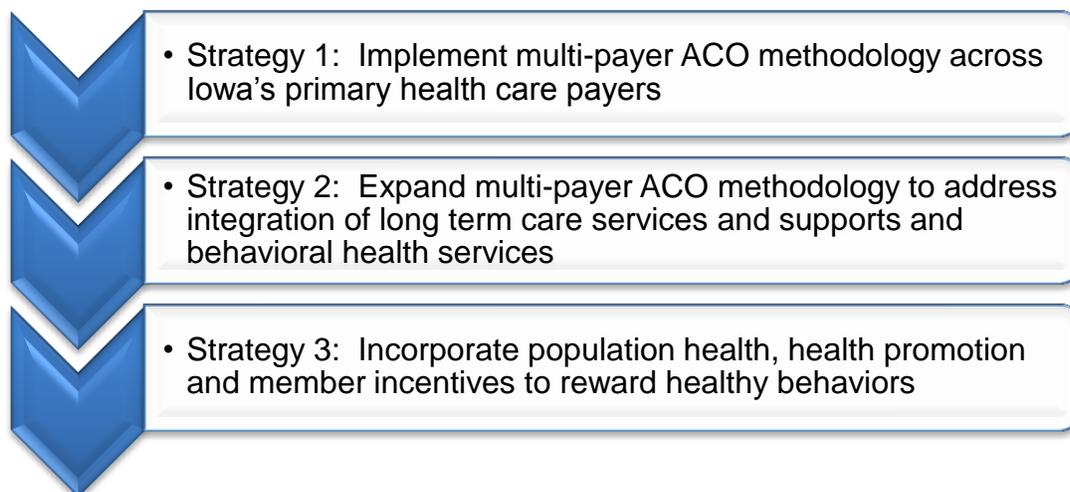
9. System transparency
  - a. The data are timely and secure with the least administrative burden.
  - b. There is access by care givers across time, place, and discipline to patient-level data for care management.
  - c. There is dependable and secure connectivity.
  - d. Iowans have easy access to their data, and they are aware of their choices and rights.
  - e. Patients recognize the benefits of enhanced provider communication as an efficient and secure way to improve their health.
  - f. Patients find healthcare accessible, which includes location options and flexible scheduling options.
  - g. Provider performance reports offer information that can be used to inform contracts, payment tiers, benefit design, performance incentives, and clinical recognition.
  - h. Data is made available for research and evaluation purposes to ensure accountability and to measure performance and impact while ensuring patient confidentiality.
10. Alignment in measures and analytics
  - a. The State has measures for performance evaluation that are standard statewide; there is a formal process to facilitate and ensure these measures evolve consistently and as needed. Stakeholders are consulted and included in discussions and decisions on how these standards should change.
  - b. The measures are actionable and represent a population health focus that promotes system transformation and better overall public health.
  - c. Iowans who move from one payer to another are aware of the alignment in measurement objectives of the providers.
  - d. The state and the health care community have reached its spending objectives, reduced the cost of care, and have established processes to continuously monitor and manage total cost of care for Iowans.

These principles are addressed throughout this SHIP, and are reflected in the strategies below.

## **Proposed Strategies**

This vision, these goals, and the organizing principles will drive the implementation of the SHIP. The following strategies were introduced in the State's SIM Design grant application and have been developed further over the past eight months. These strategies will transform Iowa's health care system and help the State achieve its goals for this transformed system.

**Figure 1: Strategies for State Innovation Model**



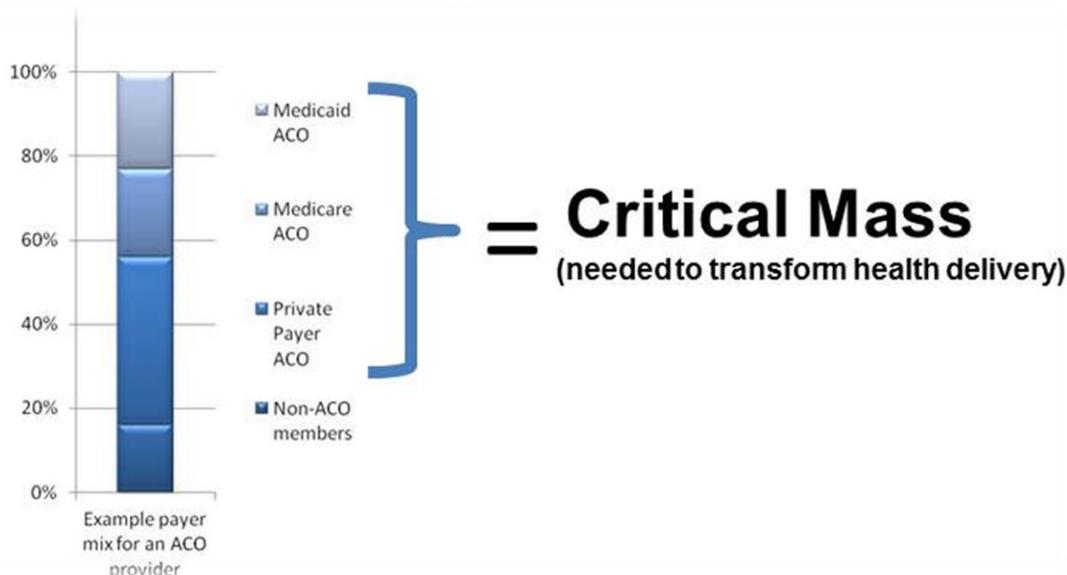
### **Implementing a Multi-Payer ACO Methodology**

Iowa's health care system consistently ranks among the top five states in the nation for cost effectiveness and quality. However, despite these rankings, commercial premiums for families and employers, and the state's funding obligations for Medicaid, continue to rise at unsustainable levels and as the population ages there is growing concern over a shortage of providers and other health care workers. Recognizing these challenges, in 2011, Governor Terry Branstad convened a workgroup of health care leaders to develop recommendations that would address the rising cost of health care and ensure Iowans are healthier. This workgroup included the state's largest health care providers, both medical schools, the state's largest commercial insurer, Medicaid, and other state leaders. The recommendations of that group involving health care delivery reform were embodied in the State's State Innovation Model (SIM) Design grant application and have been refined and further developed over the past six months.

One of the primary recommendations from this group was to implement a multi-payer Accountable Care Organization (ACO) with aligned performance measures, shared savings methodology, and integrated information technology (IT) platform to support the ACOs. Iowa is unique in that one payer – Wellmark Blue Cross Blue Shield (Wellmark)- is the predominant purchaser across small group (63.2% of the market), large group (77.1% of the market) and individual markets (84.0% of the market).<sup>1</sup> In 2011, Wellmark began working closely with key integrated health systems in Iowa to develop a framework for a value-based reimbursement model. The model was implemented with health systems across the State starting in 2012. The group recognized that: (1) together Wellmark and the State – through the Medicaid program – cover 70% of Iowans and (2) that the large health care systems need enough 'critical mass' in order to move their organizations to population based care. These systems need the leverage and consistency to reorganize to manage the financial impacts of reductions in usage of hospital care. Aligning Medicaid and Wellmark can create this leverage to encourage provider delivery systems to change their business models, which will benefit all Iowans,

regardless of payer. Iowa will seek Medicare participation also, which would bring total lives covered to 86% of lowans.

**Figure 2: Example of Provider Operating in Multiple ACO Agreements with Different Payers**



### Alignment in Measures

The first strategy is to implement a multi-payer ACO Model by adopting and adapting the ACO Model developed by Wellmark Blue Cross Blue Shield (Wellmark), Iowa's largest commercial payer. Iowa's goal is to incorporate Medicaid and Children's Health Insurance Population (CHIP) populations across the state into the ACO model through a phased-in approach and also to build upon lessons learned from the Pioneer and Medicare Shared Savings Plan (MSSP) ACOs operating in the State.

To ensure Iowa providers are working toward the same goals and are focusing on the same measurements regardless of payer, the State ACOs will use the same quality measures, the Treo Value Index Scores (VIS)<sup>TM</sup> in use by Wellmark. The VIS is a composite of seven key domains designed to promote the use of medical home concepts and support system transformation that both improves quality and lowers cost. Common use of the VIS will also bring consistency to the provider level in that there will be common dashboard reports and tools. These will enable providers to gauge their performance relative to other providers and to identify areas for improvement. Through this approach there will be alignment in accountability and payment. More information on the VIS is described in Section 7 of this SHIP document.

The State recognizes that individuals receiving coverage through the Medicaid program often have health care needs that differ from commercially insured populations. These additional needs include long-term care services and supports and may include additional treatment needs for behavioral health. To address these important services and to ensure the ACOs also focus on these important services and benefits for some

of the most vulnerable Iowans, the State will include additional performance measures and leverage financial incentives in these areas.

The State also recognizes that children are a priority population and ensuring their health and well-being in a holistic manner that includes health, education and other socio-economic factors is paramount to achieving long-term improved health and reductions in health care costs. To address this and to ensure that the unique needs of children are being met, the State is developing mechanisms and measures to ensure that the unique needs of children, including but not limited to those with complex conditions and special health care needs, will be a focus of care. This means there will be emphasis on preventive services as well as addressing the social and economic determinants of health. This will also result in longer-term savings and improvements in health and will ensure close attention is paid to the important roles that families and communities play in the health and well-being of children.

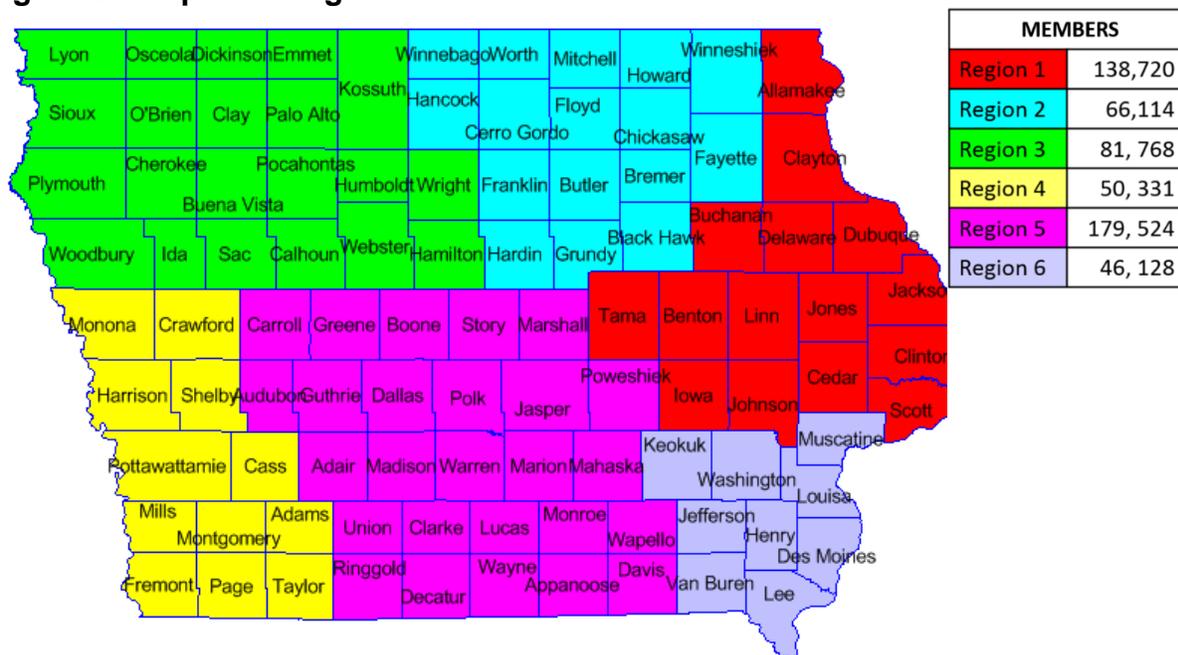
### Regional Approach

The State intends to implement the ACO model as a regional model for several reasons. Iowa is a very locally-controlled state, with 99 counties and 101 local public health departments. Iowa is also a rural state; a higher percentage of Iowans live in rural areas than do nationally and 79 of the 99 counties are rural according to the Office of Management and Budget (OMB) rural definition. Even the non-rural areas do not have large population centers and instead of one or two large urban centers, Iowa has nine or 10 smaller regional centers across the state. Only one city, Des Moines, has a population over 200,000. Cedar Rapids is the only other city with more than 120,000 residents. While these smaller urban areas limit the number of physicians who can be supported at these centers, their regional distribution does make specialized services more accessible for more people. These smaller dispersed urban centers also lend themselves to a regionally-based approach to providing health care.

Regionally-focused health care delivery systems are also likely to be more attentive and responsive to the unique needs of each community and more aware of local resources, including those in areas such as education and social and economic supports. These resources will be integral parts of effective care coordination and will be especially important in addressing the needs of children, individuals needing long-term care services and those needing behavioral health services. In addition, by dictating regional service areas, the State can ensure that the health care system, specifically regional ACOs, will be large enough to ensure financial capacity to manage risk and to develop the infrastructure necessary to coordinate care, but small enough to allow for local approaches to care. Finally, the regional approach will ensure full coverage by at least one ACO in every part of the state so that the entire state (including rural areas) receives the benefits of being part of an ACO. Statewide Medicaid ACOs will also provide a foundation for expansion of the Medicare and ACOs operating in some communities.

Recognizing these features of Iowa and the benefits of a regional approach, the State has used resources made available with the SIM design grant to analyze Medicaid claims data for the purpose of defining these regions. Analyses of claims data allowed the State to examine practice and referral patterns, noting where there were natural concentrations of activity; and identify naturally-occurring medical neighborhoods. Preliminary analysis suggests six regions in Iowa, as illustrated in Figure 3 below. Enrollment numbers appear to the right of the figure.

**Figure 3: Proposed Regions**



**Note:** Regions defined by analyzing CY2012 Iowa Medicaid claims data to observe medical neighborhoods at the zip code level and drawing hard geographic lines at the county level. LTC (institutional), Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare populations have been excluded from the analysis.

The State plans to conduct a competitive procurement process to select ACOs to provide care in each region.

### Integration of Long Term Care Supports and Services (LTCSS) and Behavioral Health (BH)

As noted in the first strategy, Medicaid enrollees have unique needs particularly for long term care services and supports (LTCSS) and behavioral health (BH).

Medicaid is the single largest payer for paid long-term services and supports. Nationally:

- Medicaid pays for 62.3% of paid LTCSS;
- Nearly 22% (21.6 %) is paid out-of-pocket;
- Other private payers pay for only 11.6%; and
- Other public payers pay just over 9% (9.1%).

In 2011, total spending for LTCSS expenditures from all sources was \$211 billion of which Medicaid expenditures were \$131 billion.<sup>2</sup> About half of Medicaid LTCSS spending pays for services for persons aged less than 65. Notably, available data underestimates the amount of out-of-pocket (OOP) spending for LTCSS because existing surveys do not capture all OOP spending on LTCSS (for example, OOP spending for assisted living is not reported, although it may be substantial). In addition, estimates are that family caregivers provide nearly \$500 billion worth of unpaid services.<sup>3</sup> In Iowa the estimate is \$4.1 million.<sup>4</sup>

Medicaid enrollees also have higher rates of mental illness and substance use disorders so the program provides a more expansive array of behavioral health services than commercial plans do. The State will be augmenting the VIS with additional measures to ensure needs are met and to support and encourage providers and the overall system to becoming more integrated. For LTCSS, one of the goals will be to increase the use of home and community based services over more costly institutional services. All of the work done to integrate long term care into the ACOs will be coordinated with Iowa's BIPP design and meet its requirements for a single point of entry system for services, standardized assessments, and conflict-free case management.

For the provision of BH services, strategies and work will build off the new Integrated Health Home (IHH) model implemented in July, 2013, as well as the work done as part of the recent redesign of the State's mental health and disability system. The redesign will transition the BH system from one that is county-led to one that is regionally-led.

## **Encouraging Healthy Behaviors**

The final strategy will support Governor Branstad's Healthiest State Initiative. Recognizing that 90% of health is attributed to environmental factors and unhealthy behaviors while only 10% is related to health care,<sup>5</sup> the State will use its role as a primary payer for health services to promote expanded use of preventative care, adoption of healthy behaviors and improved member engagement in taking responsibility for their health and well-being.

## **Phased-In Approach**

Transforming the health care system from one that is primarily unmanaged care provided in a siloed, fee-for-service, volume-based purchasing environment to a system that is value-based, accountable, integrated, and in which data are standardized is an enormous undertaking. To do this, Iowa will build upon and leverage strengths in the existing system, incorporate and align recent initiatives, expand upon what is working well, and implement new contracts, measures, and expectations across the systems. The State will also implement the components in phases to ensure success.

- Phase 1 is the implementation of the Iowa Health and Wellness Plan in January 2014.

- Phase 2 is the implementation of regional ACOs statewide in early 2016. In Phase 2, ACOs will be accountable for total cost of care and quality measures for lowans, but behavioral health and long term care supports and services will not be included in their accountability
- Phase 3 will expand the level of ACO accountability. In Phase 3 the ACOs will begin to be accountable for behavioral health services and costs, starting in early 2017. In early 2018, ACOs will be accountable for long term care supports and services. Details about each phase are provided throughout this SHIP, and are illustrated in Figure 4 below.

**Figure 4: Phases and Triggers**

Proposed Triggers and Timing for Increasing Total Cost of Care (TCOC) Accountability			
Phase 1 – Wellness Plan ACOs <i>Start 1/1/2014</i>	Phase 2 – Regional Medicaid ACOs <i>Start Early 2016</i>	Phase 3.a. – Add in BH Services to TCOC <i>Start Early 2017</i>	Phase 3.b. – Add in LTCSS to TCOC <i>Start Early 2018</i>
<b>Proposed readiness requirements for ACO receiving increased shared savings</b>			
	Trigger: ACO Proposals show readiness	Trigger: ACOs VIS measures around BH show readiness to coordinate these services	Trigger: ACOs VIS measures around LTCSS show readiness to coordinate these services
<ul style="list-style-type: none"> <li>• Wellness Plan members have access to primary care</li> <li>• Member outreach and engagement strategies</li> <li>• Incentives align with members' health behaviors</li> <li>• Incentives for system improvement through Value Index Score (VIS) quality measurements</li> <li>• <i>No shared savings or downside risk initially (will be added in subsequent years)</i></li> </ul>	<ul style="list-style-type: none"> <li>• Well defined care coordination program</li> <li>• Community relationships with traditional and non-traditional providers established</li> <li>• ACO payment structure               <ul style="list-style-type: none"> <li>• Shared savings triggered by VIS and TCOC outcomes</li> <li>• ACOs choice:3 risk levels</li> </ul> </li> <li>• Up and down side risk</li> <li>• Some BH and some LTCSS expenditures not included in TCOC calculation</li> </ul>	<ul style="list-style-type: none"> <li>• Established IHH capacity to serve Serious &amp; Persistent Mental Ill (SPMI) population</li> <li>• Established formal relationships with IHH providers</li> <li>• Refined care coordination program to account for complexities of population with high Behavioral Health needs</li> </ul>	<ul style="list-style-type: none"> <li>• Established formal relationships with all Long Term Care (LTC) provider types, including but not limited to those serving individuals with Intellectual Disabilities</li> <li>• Demonstrates data sharing capabilities with LTC providers</li> <li>• Demonstrated Balancing Incentive Payment Program (BIPP) with increased percentage of home and community based (HCBS) spending</li> <li>• Refined care coordination program to account for population complexities</li> </ul>

## **Phase I: Early Initiation of Strategies 1 and 3**

In May 2013, the Iowa Legislature passed the Iowa Health and Wellness Plan which will offer coverage to adults who are ages 19 through 64 who are not eligible for Medicaid under any other eligibility category and whose incomes do not exceed 133% of the Federal Poverty Level (FPL). Coverage is scheduled to be effective on January 1, 2014. Individuals with incomes below 100% of the FPL will be enrolled in the Iowa Health and Wellness Plan. The Iowa General Assembly and Governor Branstad very deliberately aligned the concepts and approach to providing health care services for this new population with the SIM model that was being developed for the entire Medicaid population. Because the Iowa Health and Wellness Plan was to be up and running in January 2014, the State recognized that aligning it with the comprehensive, statewide, long-term plan would accelerate the transformation and push providers and the ACOs to be ready for implementation on a broad scale. Like the SIM model, the Iowa Health and Wellness Plan uses delivery system innovation, care management, care coordination and quality approaches to realign the delivery system to focus on value, quality, and coordination of care. Individuals in the Iowa Health and Wellness Plan will be enrolled in ACOs where they are available. In preparation for this initial enrollment the State has already drafted contracts and been considering the quality metrics and financial incentives that will be used to hold providers accountable for care. While the statewide Medicaid ACOs for all members will have different incentives and requirements, the process underway with the Iowa Health and Wellness Plan will inform future requirements.

The Iowa Health and Wellness Plan, as proposed, also contains a unique incentive program that is intended to improve the use of preventive services and other healthy behaviors through the elimination of monthly financial contributions for those who complete preventive health service requirements (strategy 3). To support members in using preventive services and adopting healthy behaviors, providers will also be eligible for financial rewards for providing well exams to a specified percent of their members. More information about the Iowa Health and Wellness Plan is provided in Section 10.

## **Stakeholder Engagement**

The State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process. A communication plan was developed that included formal meetings, informal meetings and use of the Iowa Medical Enterprise (IME) website to provide information. The State sponsored the following formal stakeholder activities:

**Table 1: Stakeholder Activities**

<b>3 Learning Sessions</b>	<b>4 Workgroup Sessions (each met 4 times)</b>	<b>6 Listening Sessions (SIM and Iowa Health and Wellness)</b>	<b>2 Consumer – Focused Meetings</b>	<b>1 Steering Committee Meeting</b>
SIM overview	Metrics & Contracting	August 16: Newton	October 28	October 30
LTCSS Overview	Member Engagement	August 27: Council Bluffs	October 29	
Wellmark ACO	BH Integration	September 17: Fort Dodge		
	LTCSS Integration	September 20: Waterloo		
		September 27: Cedar Rapids		
		September 27: Cedar Rapids		

### **Workgroup Sessions**

Workgroup members were appointed by the Director of the Department of Human Services in collaboration with the Governor's office. The members represented a broad spectrum of stakeholders including, providers, payers, physicians and practitioners, managed care companies, and staff from state agencies such as Department of Public Health and Environment and Department of Insurance. The four workgroups were built around the key strategies outlined in the original grant proposal:

1. Metrics & Contracting: this workgroup was tasked with developing recommendations and goals around the structural arrangement of the ACOs, payment provisions and metrics and measures to use.
2. Member Engagement: this workgroup was tasked with developing goals and recommendations about approaches to engaging members in their own care and encouraging them to be active participants in becoming healthier. There was also discussion about how to include and incorporate the strengths of the public health system in order to address population health and achieve the Governor's Healthiest State Initiative.
3. Behavioral Health Integration: this workgroup discussed measures that should be used to ensure accountability for behavioral health care needs, considerations for including the safety net providers in any ACO arrangement and the importance of building upon the strengths of the Integrated Health Home and the current Iowa Plan and its additional services and focus on recovery.
4. Long-term Care Supports and Services Integration: this workgroup focused on the best approach to integrating these important services into the ACO model, what care coordination should look like and what types of measures will encourage and support increased use of home and community based services.

Workgroups were tasked with developing recommendations which were presented to the State and the Steering Committee to consider for inclusion in the SHIP and the ACO model. Workgroup members did not vote on any suggestions nor were they asked to come to consensus on adopting the suggestions. They did, however, prioritize the suggestions as a "1", "2", or "3". Many of these suggestions, as well as some others identified by the SIM team and those attending the listening sessions are in the recommendations that have been included in the SHIP.

Each workgroup met four times for two hours. All workgroup meetings were open to the public and there was always time at the end for public comment. There were regularly between 20 and 40 non-members attending each meeting. The meetings were held during the weeks of: July 22, August 5, August 19 and September 2. Supporting reading, agendas and minutes were all posted on the IME SIM website. Although the specific areas of focus differed, the workgroup meetings were arranged as follows:

- Workgroup meeting #1: Level setting with a focus on the entire project, the need for transformation and an introduction to the ACO concept.
- Workgroup meeting #2: Analysis and discussion of what works in the system of focus (LTC, BH, etc.), what doesn't work, and the goals and visions for a transformed system. From these workgroups, four summary documents of the key themes identified in each workgroup were developed.
- Workgroup meeting #3: Focus on developing 10 to 12 recommendations. These recommendations were then sent to the workgroups for them to identify and select their priorities. They were also asked to provide additional recommendations which might not have been mentioned. These priorities were then compiled into a summary document and shared prior to the fourth workgroup.
- Workgroup meeting #4: Focus on discussing and refining the recommendations, and soliciting any additional recommendations. Members were also asked to comment on priorities and discuss whether they would shift any of the priorities after further thought.

The fifth workgroup is a consumer-focused workgroup that met on October 29 and October 30, 2013. During these meetings IME provided an overview of the project, discussed the workgroup approach and shared the recommendations and goals that were presented to the Steering Committee. The focus was on the impact of the transformation on Medicaid enrollees and other Iowa health care consumers.

## **Listening Sessions**

The State is committed to making sure that individuals not included in the workgroup process, as well as those outside of Des Moines had opportunity to hear about the SIM process and to share their thoughts. Because the Iowa Health and Wellness Plan was a topic of great interest and because its planning and implementation is laying the foundation for the ACOs that will be put in place for all Medicaid enrollees during the SIM process, the State discussed both initiatives at these sessions.

## **Steering Committee**

The Steering Committee also met at the end of the workgroup process to provide their opinions on the workgroup recommendations. They did not formally vote on the recommendations but there was opportunity for questions and discussion after the Governor's Health Policy Adviser and the Medicaid Director provided detail about the proposed approach. Steering Committee members responded favorably to the recommendations and commended the IME on the stakeholder-inclusive process. Many of the Steering Committee members were part of the workgroup of health care leaders that Governor Branstad had convened in 2011. Appendix D provides the names and organizations of the workgroup and Steering Committee members.

## **Document Preparation for Internal and External Usage**

To ensure information and progress updates were available to a wide audience, the State posted meeting agendas, meeting minutes, presentations and resource documents on the newly-developed SIM website (<http://www.ime.state.ia.us/state-innovation-models.html>). The SIM team developed multiple documents and papers that were used to provide additional information to workgroup members and meeting attendees, Steering Committee members, and other stakeholders interested in the SIM project. These documents included summaries of best practices around accountable care models, integration of LTCSS, integration of behavioral health services; and member and public health engagement strategies. The team also produced multiple data reports and shared them with the workgroups and State leaders.

Additionally, the team created documents that summarized workgroup input at various stages of the workgroup meetings. These summaries were used in workgroup meetings to ensure that the team was capturing stakeholder input accurately, and to allow workgroup members to see (and comment on) the full range of recommendations that were being made by the four work groups. At the last workgroup meetings, the full recommendations document for each workgroup was reviewed for any additional input and feedback.

## **Integrated Health Care Models and Multi-payer Delivery Systems Study Committee Meeting**

The legislation authorizing the Iowa Health and Wellness Plan also created an Integrated Health Care Models and Multi-payer Delivery Systems Study Committee. This Committee has the responsibility to:

- Review and make recommendations for the formation and operation of integrated care models in Iowa;
- Review integrated care models adopted in other states that integrate both clinical services and nonclinical community and social supports utilizing patient-centered medical homes and community care teams;
- Recommend the best means of incorporating into integrated care models nonprofit and public providers that care for vulnerable populations;

- Review and make recommendations regarding development and implementation of a statewide medical home infrastructure to act as the foundation for integrated care models; and
- Review opportunities under the federal Affordable Care Act for development of integrated care models; address consumer protection, governance, performance standards, data reporting, health information exchange, patient attribution, and regulation issues relative to integrated care models.

The Committee also serves as a legislative advisory council on multipayer health care delivery systems to guide the development by the DHS of Iowa's design model and implementation plan for the SIM.

On November 19 and 20, 2013, the Committee sponsored a multi-session meeting that covered a variety of topics, including but not limited to:

- Iowa's health care delivery system and opportunities for further integration which included a session on ACOs – both commercial and Medicare;
- Community engagement which included presentations on addressing determinants of health in an integrated system and the role of local public health systems in an integrated system;
- Addressing determinants of health in an integrated system;
- Health IT and the importance of data analytics;
- The role of the Medicaid program in the integrated system with a discussion of the SIM as well as the Health Home and Integrated Health Home initiatives;
- Quality and using payment to incentivize an integrated system;
- Workforce and delivery strategies to ensure access; and
- Addressing unique populations, including presentations on children's health, older Iowans and behavioral health.

Both IME staff and all SIM workgroup chairs were presenters; two of the four SIM workgroup chairs also moderated several sessions. Several staff to Committee members regularly attended the workgroup sessions to ensure Committee member knowledge of discussions and decisions. The Governor's Executive staff and this Committee will continue to collaborate and communicate as the ACO design evolves and is implemented.

The State considers stakeholder engagement an ongoing strategy that will ensure that all perspectives are heard and considered for incorporation in the ACO model. The specific approach to continued engagement has not been decided but workgroups and the Steering Committee have all expressed interest in ongoing involvement.

## 2. Population Demographics (Responds to Question 2)

### Rural and Older Population

In 2012 Iowa was home to 3,074,186 people, a high percentage of whom live in rural areas (36% compared to 19% nationally).<sup>6</sup> In terms of age, Iowa closely resembles national averages, with the exception of having a higher percentage of the population who are 55 years old or older.

**Table 2: Age of Iowans (in years)**

Age Category	Iowa	US
0-18	25.6%	25.8%
19-25	9.8%	9.8%
26-44	23.4%	25.1%
45-54	14.5%	14.6%
55-64	12.4%	11.9%
65+	14.3%	12.8%

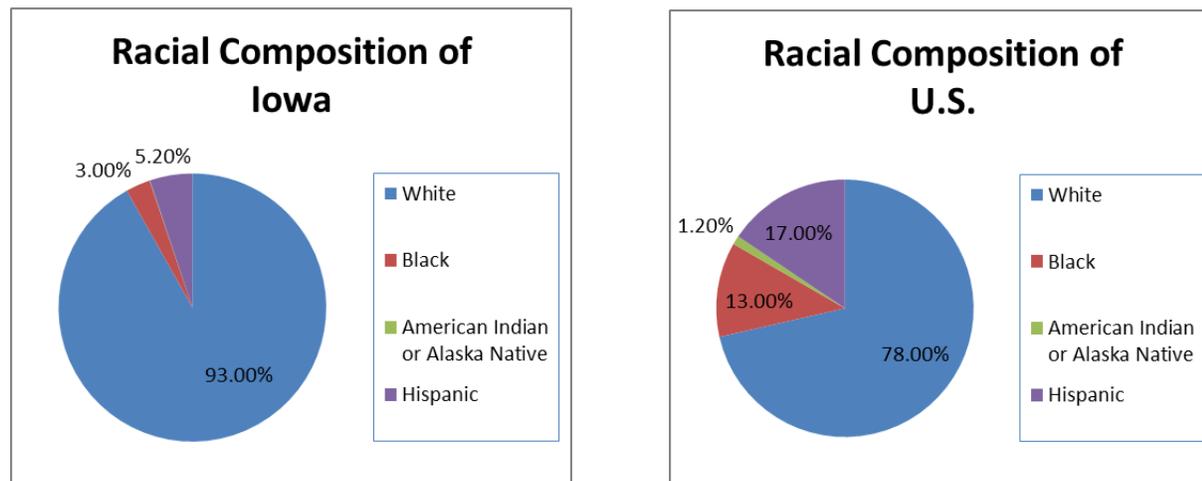
Source: U.S. Census Bureau, American Community Survey. (2011). *Iowa State Quick Facts*.

In sum, the average age of Iowans is slightly older than the national average and there is a much higher percentage of people living in rural areas than there are nationally (more than 50% higher). These differences will require focus on providing care in rural areas and addressing the needs of an aging population. The regional ACOs are expected to ensure comprehensive, accountable care in rural areas as ACOs will be required to provide services in an entire region.

## Race and Languages Spoken

As shown below in Figure 5, there are far fewer minorities (as a percent of total population) in Iowa than there are nationally.

**Figure 5: Racial Composition of Iowa and the U.S.**



Source: U.S. Census Bureau; American Community Survey. (2011). *Iowa State Quick Facts*.

According to several stakeholders, the fact that Iowa has fewer minorities means the State has focused less attention than other states have on ensuring members can receive care in the language and culture in which they are comfortable. However, the racial make-up is changing: between 2000 and 2010 the population of Iowa increased 4% but there was an 84% increase in the number of individuals identifying themselves as Hispanic.<sup>7</sup> Moreover, the younger population is much more diverse than the older population: while only 2% of those over 65 are of color, 15% of young children (age 0 – 5) are. Also of importance, racial disparities are especially evident for children (0-18) with special health care needs (CSHCN): 15% of white children while 21% of black children fall into this category.<sup>8</sup> The changing demographics will have their biggest impact on the delivery of child health services and on the long-term efforts to reduce or eliminate disparities in health by race and ethnicity. Concurrent with these racial demographic changes, the percentage of Iowans that speak a language other than English and don't speak English very well has more than doubled.

**Table 3: Languages Spoken in Iowa Households**

Languages Spoken in Iowa Households	1990	2000	2011
Speak only English	96.1%	94.2%	92.7%
Speak language other than English	3.9%	5.8%	7.3%
Speak English "very well"	2.5%	3.4%	4.3%
Speak English less than "very well"	1.4%	2.5%	3.0%

Sources: US Census Bureau, 2011 American Community Survey (ACS); 2000 Decennial Census; Steven Ruggles, Matthew Sobek, Trent Alexander, et al., *Integrated Public Use Microdata Series: Version 3.0* [IPUMS 1990 5%]

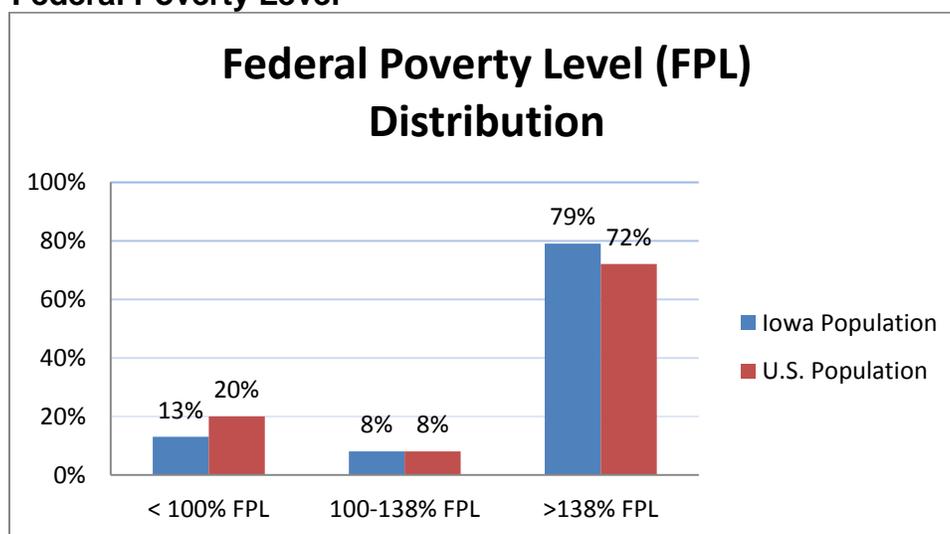
(Minneapolis, MN: Minnesota Population Center, 2011)  
<http://www.migrationinformation.org/datahub/state2.cfm?ID=IA>

The State recognizes that these demographic changes will require greater attentiveness to language and cultural needs as well as a need to recruit providers that reflect this changing demographic. This will be a responsibility of each ACO and the State will work closely with them to develop best practices that are based on the needs of the Iowa population as well as successful strategies employed in other states with greater ethnic and cultural diversity.

## Poverty and Health Insurance Coverage

Social and economic factors are often correlated with health status and well-being. Multiple studies have shown that families and children living in poverty are more likely to have poorer health statuses; additionally, racial and ethnic minorities are more likely to be in poorer health.<sup>9101112</sup> The poverty rate in Iowa is lower than the national rate but even so about 13% of Iowans were in poverty (below 100% of the Federal Poverty Level(FPL)), and another 8% were living between 100-138% FPL.<sup>13</sup>

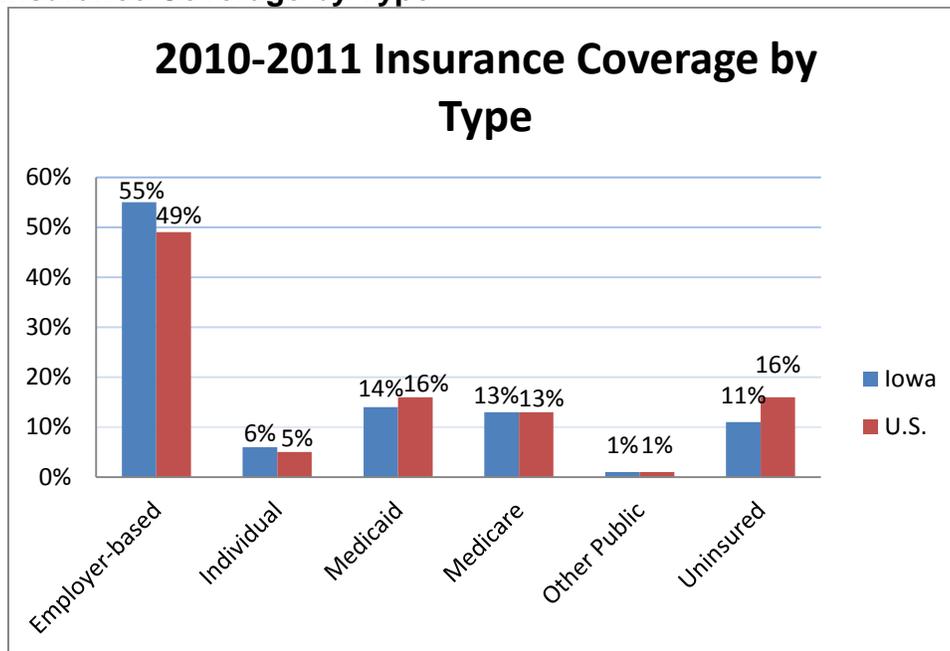
**Figure 6: Federal Poverty Level**



Source: Kaiser Family Foundation <http://kff.org/other/state-indicator/distribution-by-fpl/>

Using 2010-2011 Current Population Survey data, analysis conducted by Urban Institute and the Kaiser Family Foundation show that about 55% of Iowans were covered by employer-based insurance (national rate is 49%); 14% were enrolled in Medicaid (national rate is 16%); 13% were enrolled in Medicare (national rate is the same), 6% had individual insurance, and 1% had other public insurance. The remaining 11% were uninsured, which is lower than the national average of 16%.<sup>14</sup> Among those that are insured, more than three-quarters are covered by Wellmark.<sup>15</sup>

**Figure 7: Insurance Coverage by Type**



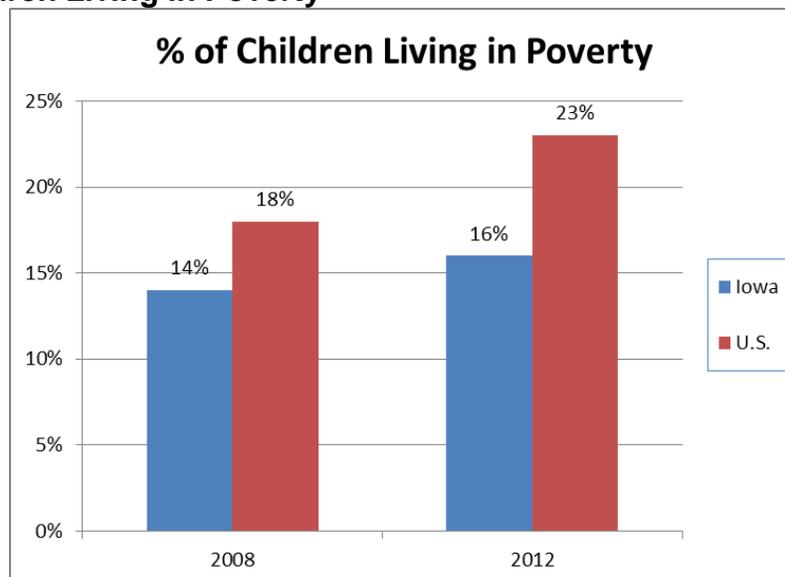
Source: Urban Institute and the Kaiser Family Foundation analysis of 2010-2011 Current Population Survey data.

While only 16% of all lowans are covered by Medicaid, the program is the primary insurer for children and covers more than half of all young children (age 0 – 5).

## Iowa's Children

Similar to the overall population, in 2012, the poverty rate of Iowa's children—16%—is lower than the national rate of 23%.<sup>16</sup>

**Figure 8: Children Living in Poverty**



Source: Kids Count Data Center. 2012. *Children in Poverty*. <http://datacenter/kidscount.org/data/tables/>.

However, this rate is higher among very young children (those under age 5): one in five live in poverty.<sup>17</sup> Children are the age group in Iowa most likely to live in poverty, at more than twice the rate for those over 65. It is also of concern that for every 100 Iowa families living in poverty, only 34 received Temporary Assistance for Needy Families (TANF) benefits (data are from 2008-2009).

There is no difference between the rate of urban youth living in poverty (below 100% FPL) and the rate for rural youth (17% for both groups). When the data are analyzed for all "low income" children (below 200% FPL), the rate is higher among rural youth—41%—than it is for urban youth—36%.<sup>18</sup>

## Demographics of Medicaid Enrollees

In Iowa's Medicaid program, like other Medicaid programs, the majority of enrollees are children.<sup>19</sup> Prior to the ACA, this percentage in Iowa was 60.8% (60.7% nationally).<sup>20</sup> After the expansion (the Iowa Health and Wellness Plan), the percentage of Medicaid enrollees that are children drops to 52.2% (50.2% nationally). Where Iowa differs, quite dramatically, is the percent of enrollees that are not white or that speak a language other than English. This is not surprising given the demographics of the entire state.

**Table 4: Race and Languages Spoken of Iowa Medicaid Enrollees**

Distribution of Medicaid Enrollees	Iowa Pre-ACA	Iowa Post-ACA	US Pre-ACA	US Post ACA
<b>Race</b>				
White	77.4%	79.5%	43.1%	46.3%
Black	7.6%	6.8%	21.4%	20.2%
Hispanic	9.7%	8.6%	27.6%	25.7%
Other	5.2%	5.0%	7.9%	7.8%
<b>Language Spoken at Home</b>				
English	85.8%	86.7%	66.0%	67.6%
Spanish	6.6%	5.8%	21.3%	19.6%
English and Other	3.7%	3.7%	5.2%	5.6%
Other	3.9%	3.8%	7.4%	7.2%

Source: Urban Institute estimates based on ACS-HIPSM, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2013. Available at: <http://kff.org/interactive/zooming-in-health-reform-medicaid-uninsured-local-level/>

## Demographics of CHIP Enrollees

The CHIP program in Iowa has three parts: a Medicaid expansion, a separate program called Healthy and Well Kids in Iowa (*hawk-i*), and a dental-only plan. The Medicaid expansion provides coverage to children ages 6-18 whose family income is between 100% and 133%FPL, and infants whose family income is between 185% and 200% FPL. The *hawk-i* program provides coverage to children under age 19 in families whose

gross income is less than 300% FPL who are not eligible for Medicaid or the Medicaid expansion. Families with incomes in the upper end of the range pay a premium not to exceed \$40 a month. In 2010, the IME implemented a dental-only plan for children who meet the *hawk-i* program's income guidelines but do not qualify for full coverage because they have health insurance. Two managed care plans and one dental-only plan are available to families eligible for *hawk-i*. United Healthcare, Wellmark Health Plan of Iowa, and Delta Dental of Iowa are currently available in all 99 Iowa counties.<sup>21</sup>

In SFY 2012, the CHIP program (all three components) covered 56,067 children with the majority (64%) enrolled in *hawk-i*. The State projects that a total of 64,995 children will be covered in SFY14 and 69,459 children will be covered in SFY15.

The typical *hawk-i* family has four members, is white, has children between the ages of 6-12, income between 151% and 200% FPL and pays a total premium of \$20 per month.<sup>22</sup>

## Demographics of Medicare Beneficiaries

The demographics of Iowa's Medicare population are somewhat different than that of the overall U.S. Medicare beneficiary population. These differences are to be expected given the more racially homogenous population and the lower rates of poverty (the percentage of Medicare beneficiaries that are enrolled in Medicaid is lower in Iowa than it is nationally).

**Table 5: Medicare Beneficiary Demographics**

State and National Comparison of Medicare Beneficiary Demographics		
Category	Iowa	U.S.
% of Female Beneficiaries	56%	55%
White Beneficiaries Average Age	72.88 years	71.22 years
% of White Beneficiaries	96%	77%
Medicaid-enrolled	16%	21%

Source: Kaiser Family Foundation. *State Health Facts: Medicare*. <http://kff.org/state-category/medicare/>

## 3. Population Health Status and Issues or Barriers (Responds to Questions 3 and 10)

### Population Health Status

#### Health of Iowans

Generally, Iowans are healthier than the average American. According to Commonwealth Fund analysis, Iowa's overall health ranking was 2<sup>nd</sup> in the country, and was previously ranked 3<sup>rd</sup> by the same report. The rankings were developed by

analyzing 35 total indicators of health in five categories. Table 6 below describes the categories and provides Iowa's rankings in 2007 and 2009.

**Table 6: Health Ranking**

Category	Iowa's 2009 Ranking	Iowa's 2007 Ranking
<b>Access</b>	4	4
<b>Prevention and Treatment</b>	6	5
<b>Avoidable Hospital Use and Costs</b>	14	12
<b>Equity</b>	8	15
<b>Healthy Lives</b>	7	8

Source: Commonwealth Fund. 2009. *Scorecard on Health System Performance*.

Using a different methodology, the Gallup Healthwise Poll, Iowa ranked 9<sup>th</sup> (2012 data). Since 2010, when Governor Branstad implemented the Healthiest State Initiative, Iowa has moved up ten positions.

Iowans self-reported health status is better, relative to national data. Only 13% of Iowans report that their health is fair or poor, compared with 17% of people nationwide. Additionally, the percentage of Iowans (20.6%) with diabetes, cardiovascular disease and/or asthma is lower than the percentage nationally (22.5%).

**Table 7: Population Health Status**

Measure	Iowa	United States
<b>Self-reported health status, % in fair or poor health, adults, 2011</b>		
	13.0%	16.9%
<b>% with diabetes, cardiovascular disease, and/or asthma, adults, 2009-2010</b>		
	20.6%	22.5%

Source: SHADAC analysis of Behavioral Risk Factor Surveillance System (BRFSS). Prepared by the NORC technical assistance team for the State Innovation Models (SIM) project and provided in *Benchmark State Profile Report for Iowa*.

Although Iowans are generally healthy and the State has high ranks using two different methodologies, Iowa has a relatively low percentage (42.9%) of adults that access preventative health services. This low rate is concerning because primary care visits are important for controlling and managing chronic conditions, diagnosing illnesses earlier and supporting individuals in adopting healthier behaviors. Iowa also received a low ranking in the category of health equity, with disparities especially high in areas related to income and racial and ethnic groups, with 68.5% of low-income adults not accessing recommended primary care, a rate which is about 25% higher than the overall state total.<sup>23</sup> The State is confident that the ACO model will address this.

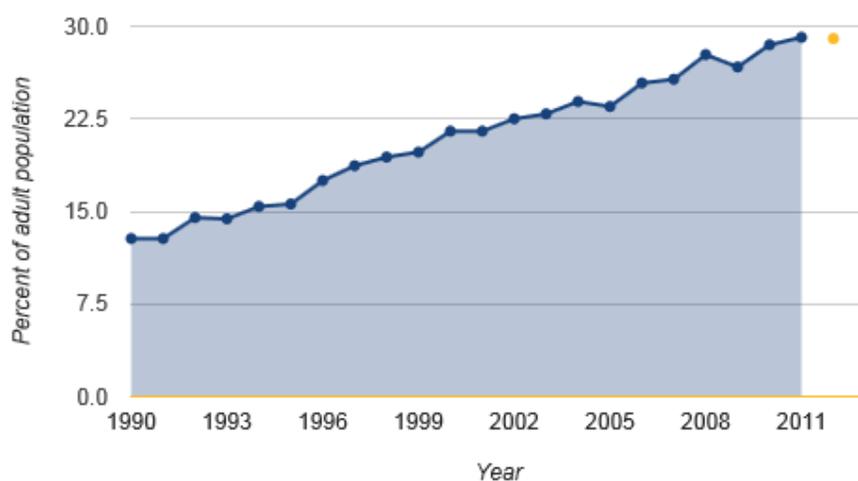
Another cohort that often suffers from poorer health status is the population that lives in rural communities. This disparity is frequently a result of fewer providers and resources in rural areas. Currently, "Access to Services" is one of the most commonly identified categories of need in Iowa counties.<sup>24</sup> Iowa is not unique in this regard and addressing the disparities in access between rural and urban areas is a primary reason for adopting

a regional approach that will require that an ACO provide services to the entire region, including rural areas.

## Obesity

Iowans have slightly higher rates of adult obesity (29%, compared with 27.8% nationally) and higher rates of adults not meeting physical activity recommendations (82.8%, compared with 79.1% nationally). Like all states, Iowa's obesity rates are increasing. Less than 25 years ago (in 1990) the rate was 12.2%.<sup>25</sup>

**Figure 9: Adult Obesity Rates 1990 - 2012**



Source: America's Health Rankings. 2012 Annual Report. <http://www.americashealthrankings.org/IA>

The percentage of children in Iowa who are obese is slightly lower than the national average (10.2% compared to the national average of 13.0%).<sup>26</sup> This lower rate may be a function of the small percentage of children who are minorities, as obesity rates are higher among non-Caucasian children. Nationally, nearly one-quarter of non-Hispanic Black children were considered to be obese in 2009-10 and another 15% were considered to be overweight. Similarly, nearly 40% of Mexican-American and other Hispanic children were either overweight or obese. In comparison, approximately 28% of non-Hispanic White children were overweight or obese.<sup>27</sup> In light of the fact that the majority of population growth in Iowa can be attributed to the increasing Hispanic population, the rate of obesity in children may increase at a faster rate. Regardless of the fact that the percentage of children that do not meet the physical activity recommendations is lower in Iowa than it is nationally, about one in two youth are not getting the suggested amount of exercise and physical activity. Addressing these risk factors now by encouraging the adoption of healthier behaviors has the potential to dramatically improve the health status of these youth both now and in the long-term. It is for these reasons that Governor Branstad has identified the need to combat obesity, especially among children, as a primary focus of the Healthiest State Initiative.

It is important to note that while Iowa's obesity rates are close to the national rates, this does not mean the rate is low. According to the World Health Organization, the United States ranks 7<sup>th</sup> in the world for the percentage of males age 15 and older that have a BMI of 25 or greater and 14<sup>th</sup> for females of the same age group. For both males and females, the countries with higher (worse) rates are primarily island countries such as Samoa and Tonga. The United States has higher rates than all other developed countries.<sup>28</sup>

The Iowa Department of Public Health (IDPH) created a Community Health Needs Assessment and Health Improvement Plan in 2011 based on input from its 99 counties. Seventy-four counties (three-quarters) of the counties cited obesity and weight status as a priority need but only 63 counties said they were addressing this need.<sup>29</sup> Despite the widely known link between diet, access to nutritious foods, and obesity, only seven counties cited nutrition as a priority need and three counties cited food access.

### Risk Factors: Lack of, Exercise and Substance Use

Exercise and activity level, use of tobacco and excessive use of alcohol all contribute to the health status of individuals. Nationally, very few adults and children meet the physical activity recommendations and in Iowa the rate for adults is slightly worse while for youth it is slightly better. Even though Iowa's rate is higher, it is important to note that about one in two children are not active enough to meet the recommendations.

**Table 8: Selected Risk Factors**

% not meeting physical activity recommendations, 2011		
	Iowa	U.S.
Adults	82.8%	79.1%
Youth	48.5%	50.5%
Rate of tobacco use, 2011		
Adults	20.4%	21.2%
Youth	18.1%	18.1%

Source: SHADAC analysis of Behavioral Risk Factor Surveillance System (BRFSS). SHADAC analysis of Youth Risk Behavior Surveillance System (YRBSS). Prepared by the NORC technical assistance team for the State Innovation Models (SIM) project and provided in *Benchmark State Profile Report for Iowa*.

In 2010, 16 of every 100 Iowa adults smoked cigarettes, while nationally the median rate was 17% (median is the rate at which half of the states had higher rates while half had lower rates). Among the 50 states, Iowa's rate ranked 19<sup>th</sup> lowest in 2010. States' rates ranged from 9% to 27%.<sup>30</sup> Tobacco use is one risky behavior for which Iowa has historically had similar rates or slightly lower rates than the national average.

However, these overall rates do not provide a complete picture of the burden of smoking in Iowa. Notably, the rates for black men exceed the rate for all other groups and those with lower incomes and less education are also more likely to smoke.<sup>31</sup> Thus, many of the individuals with the least access to health care are also those most likely to be smokers. As with some of the other measures in Iowa, the relatively small number of minorities in the State means the overall rate is highly correlated with the rate of white

lowans. With the changing demographics, the rates could increase meaning expanded tobacco prevention and cessation efforts will be increasingly important to reducing chronic and preventable tobacco-related illnesses and conditions. It is also of concern that while the rates of youth tobacco use have declined overall, the cigarette smoking rate among students in the twelfth grade (29%) is higher than the rate for every adult age group in Iowa.<sup>32</sup>

Since state estimates of substance use and abuse were first generated and released by the Substance Abuse and Mental Health Services Administration, Iowa has been among the 10 states with the lowest rates of:

- illicit drug use in the past month (all age cohorts);
- marijuana use in the past month (all age cohorts); and
- past year nonmedical use of pain relievers for those age 26 and older.

While illicit drug use is a smaller problem in Iowa than it is nationally, rates of alcohol dependence and or abuse have been consistently higher than the national rates and the percentage of lowans that report binge alcohol use (drinking five or more drinks on the same occasion on at least one day in the past 30 days) is much higher in Iowa than it is nationally.

**Table 9: Binge Alcohol Use**

Percent Reporting Binge Alcohol Use	Iowa	U.S.
Age 18 - 25	50.0%	40.2%
Age 26+	24.4%	21.8%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data - Revised March 2012).

## Mental Health

It is estimated that about 4.9% of lowans have a serious and persistent mental illness (SPMI), a slightly higher rate than the national average of 4.6%.<sup>33</sup> However, a lower percent of lowans (30.6%) report having poor mental health, relative to the U.S. average of 35.8%.<sup>34</sup> Sixty-one counties identified mental health needs as a concern and 25 reported that access to mental health services is an issue.

According to the Governor’s Healthy lowans 2010 report, the incidence of Serious Emotional Disturbances among children is 10-12%, a rate that is very similar to the national rate.<sup>35</sup> When defined more broadly, 19% of children in Iowa between the ages of 2 and 17 had a parent who reported that a doctor has told them their child has autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral/conduct problems. This rate is from 2010-2011; in 2007 the reported rate was 17%.<sup>36</sup> In Iowa, it is estimated that one-third of youth who need mental health services do not receive them (2011 data).<sup>37</sup>

## Health Status of Iowa's Children

In general, compared with the country as a whole, the health and well-being of children in Iowa is very good. Iowa has one of the highest rates of health insurance coverage in the country (97%) and 90% of children are in excellent or very good health as rated by parents.<sup>38</sup> Populations of concern include children with special health care needs, and children living in families with incomes below 133% FPL. Children with special health care needs are more likely than other children to have experience with two or more Adverse Childhood Experiences (ACEs)<sup>39</sup>. For about 40% of families of low-income children, having enough food on a consistent basis (food insecurity) is an issue. Parents of low-income children are under greater parenting-related stress and report having lower mental health status. Thus, while children in Iowa are generally healthy and connected to the health care system, health and social disparities exist for children in the state.

There are also health disparities among children with special health care needs. According to the 2010 National Survey of Children with Special Healthcare Needs, the following disparities exist: 14% of white, non-Hispanic; 10% of Hispanic; and 21% of black, non-Hispanic children report having a special healthcare need. Of these children, those that were black or Hispanic reported difficulties with access to medical homes and coordinated care, financial difficulties related to healthcare needs, and unmet needs at a higher rate than their white peers.

Medicaid and Iowa's CHIP program play a particularly important role in ensuring that Iowa's children have health coverage. Half of all Iowa children under the age of five are covered under Medicaid, and nearly four in ten children in Iowa receive coverage under Medicaid. Particularly when children are very young (0-2), child health practitioners see children frequently and are in a position to identify and respond early to potential health concerns. Moreover, Medicaid covers a greater proportion of children with special health needs and, because it is the major source of coverage for low-income children, covers a greater proportion of children who are at risk.

The obesity rate, involvement in risky behaviors, and behavioral health status for children and youth have been described in prior sections.

## Health Care Quality and Health Needs

Overall, Iowa achieves high ranks for the quality of health care provided. It is among the top 10% in overall health quality nationwide; and the Agency for Healthcare Research and Quality's June 2012 Dashboard on Health Care Quality Compared to All States, ranked Iowa 5<sup>th</sup> overall.

However, there are fewer physicians per 100,000 people in Iowa than the national average, for both primary and specialty care. There are also fewer nurse practitioners per 100,000 people in Iowa than the national average. Regarding a nurse practitioner's

scope of practice, physician involvement is not required in diagnosis, treatment, or prescribing in Iowa<sup>40</sup>.

In 2010 and 2011, the Iowa Department of Public Health (IDPH) assessed what were the most acute health needs within all counties as part of the effort to identify factors and unmet need that are influencing health outcomes. As can be seen in the table below, obesity is the number one issue and health need identified by Iowa's counties. (63%). Small and large counties both identified this issue. This county prioritization aligns with Governor Branstad's consistently focusing on obesity as a legislative and public health priority.

**Table: Top 10 Identified Community Health Needs**

Top 10 Identified Health Needs in Community Health Needs Assessment and Health Improvement Plan Process					
Health Need	Focus Area	Number of Identifying Counties	% of Identifying Counties	Number of Counties Addressing Need	% of Counties Addressing Need
<b>Obesity and Overweight</b>	Healthy Behaviors	74	75%	63	64%
<b>Access to Transportation</b>	Health Infrastructure	41	41%	7	7%
<b>Water Quality</b>	Environmental Health	41	41%	10	10%
<b>Motor Vehicle Accident Prevention</b>	Prevent Injuries	36	36%	6	6%
<b>Access to Mental Health Services</b>	Health Infrastructure	35	35%	16	16%
<b>Cancer</b>	Healthy Behaviors	35	35%	20	20%
<b>Youth Substance Abuse</b>	Healthy Behaviors	32	32%	24	24%
<b>Educational and Community Based Programs</b>	Health Infrastructure	32	32%	24	24%
<b>Lead Poisoning and Screening</b>	Environmental Health	32	32%	14	14%
<b>HIV/STD Prevention, Screening, and Treatment</b>	Prevent Epidemics	31	31%	8	8%

Looking in detail at the Chronic Disease category of IDPH's Community Health Needs Assessment, heart disease is cited as the leading need, followed by diabetes, chronic disease prevention, and respiratory disease.

**Table 11: Category Detail for Chronic Disease**

Category Detail for Chronic Disease		
Need	Identifying Counties	% of Identifying Counties
Chronic Disease Overall	48	43.4%
Heart Disease and Stroke	28	28.3%
Diabetes	11	11.1%
Chronic Disease Prevention	9	9.1%
Respiratory Disease	9	9.1%
Dementias, (including Alzheimer's Disease)	4	4.0%

There are differences in the health status of lowans depending upon where they live. For example, the age adjusted asthma rate in the northeast corner and northwest corner counties is below 4 per 10,000 while the rate in Webster County (Fort Dodge) is 19.8 per 10,000.<sup>41</sup> The age adjusted heart attack rate for individuals age 35 and older is 46.32 per 10,000 in Wapeno County in the southeastern part of the state and 5.65 in Page County in the southwestern corner.

There is also huge variation in access to services. Statewide 17.5% of pregnant women do not receive any prenatal care in the first trimester, but the county rates range from less than 15% to nearly 50%. By implementing regional ACOs, the IME expects that the ACOs will be able to focus on the areas of greatest need and also capitalize on regional strengths.

### **Health Status of Medicaid Enrollees**

In Iowa, the most common Medicaid member is, on average, a 9-year-old child who is healthy and uses very few health care services apart from well-child care, immunizations, and treatment of common childhood illnesses, such as ear infections. Medicaid covers thousands of such children for minimal cost.<sup>42</sup> At the same time, many of these children are at much higher risk of developing serious health conditions in the future, due to social and economic factors in addition to biomedical ones. While prevention strategies for adults are often viewed in terms of health maintenance, children are growing and development and prevention is much more tied to development and positively impacting the child's health trajectory.

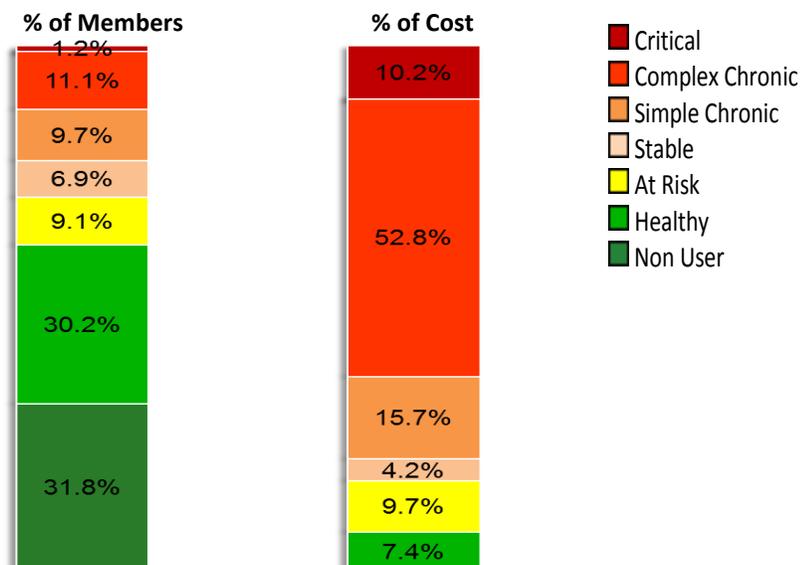
With the Iowa Health and Wellness Plan, Iowa also will be covering a much larger share of the non-elderly adult population, who have more health needs than the general population but generally are in relatively good health.

The Medicaid program in Iowa, like all Medicaid programs, also provides care to a much smaller population that has higher rates of chronic illness than the general population. Nationally, among nonelderly adult Medicaid enrollees in 2009, 10% were diagnosed with diabetes, 28% with cardiovascular disease, 23% with respiratory disease, and 35%

were diagnosed with a mental illness.<sup>43</sup> Individuals with chronic conditions are high-users of services and, therefore, consume a disproportionate share of health care spending: just 5% of Medicaid beneficiaries account for 54% of total Medicaid expenditures and 1% of Medicaid beneficiaries account for 25% of total Medicaid expenditures. Among this top 1%, 83% have at least three chronic conditions and more than 60% have five or more chronic conditions.<sup>44</sup> In Iowa, the top 5% high cost/high risk Medicaid members have an average of 4.2 chronic conditions, receive care from five different physicians and receive prescriptions from 5.6 prescribers. They account for 90% of all hospital readmissions within 30 days, 75% of total inpatient costs and 50% of prescription drug costs.<sup>45</sup>

For this SHIP, the State conducted additional analysis of its Medicaid data to assess overall disease burden. The analysis clearly demonstrates that individuals with chronic conditions account for a relatively high percentage of the health care costs. Specifically, 11.1% of the Iowa Medicaid population falls into the patient segment “complex chronic”, meaning they have medium to high illness burden with consistent use of services to treat severe or multiple chronic conditions. This group accounts for more than half (52.8%) of Medicaid expenditures. Just over 1% of the Medicaid population is in the patient segment critical, defined as someone with high illness burden, with consistent use of services for life threatening illness; about 10% of all Medicaid dollars go to providing care for this population. Based on this analysis, there were no claims submitted for 31.8% of the Iowa Medicaid population for the 12 month measurement period (CY 2012). This suggests these individuals were not engaged in the health system, although it is impossible to determine why there was no interaction for these individuals (i.e. they were unable to access services, they didn't need services or they were uninterested in receiving services). Figure 10 details this analysis.

**Figure 10: Membership by Health Segment, All Medicaid Population, CY 2012**



## Health Status of Older Iowans

As described earlier, the population in Iowa is slightly older than it is nationally and there is a higher percentage of male Medicare enrollees in Iowa. In general, Iowans are healthier than individuals in other states and this is also true for the older population.

**Table 12: Health Status of Individuals Age 50 and Older**

Health Status for Individuals Age 50 and Older		
Metric	Iowa Rate	U.S. Rate
Reporting poor or fair general health (2010)	17.1%	23.4%
High blood pressure prevalence (2009)	46.1%	49.1%
Overweight or obese (2010)	69.6%	68.3%
Diabetes prevalence (2010)	13.6%	16.9%
Report mental health was not good for >1 week in month (2010)	8.4%	12.6%

Source: M. Multack and C. Noel-Miller. December 2012. *Quick Health Facts 2012*. AARP Public Policy Institute.

Medicare beneficiaries over the age of 65 in Iowa fill more prescriptions, on average, than Medicare beneficiaries nationally: 13.3 as compared to 11.3.<sup>46</sup> It is impossible to determine from the data alone whether this contributes to the overall better health or is evidence of over-utilization of prescription drugs.

## Issues and Barriers to Improved Health

### Rural Nature of the State

Iowa is a rural state, 79 of the 99 counties have a rural designation, and even the non-rural areas do not have large population centers, rather Iowa has nine or 10 smaller regional centers across the state. While urban areas also have issues with access to care, rural areas face unique challenges in terms of access to providers, access to specialty care and access to supportive services provided in the home. In Iowa there are 86 designated medically underserved areas and nine medically underserved populations in 72 of the 99 counties. There are also 319 HRSA designated primary medical care health professional(s) shortage areas (HPSAs), 171 dental HPSAs and 229 mental health HPSAs.<sup>47</sup> Half of Iowa counties are located in HPSAs.

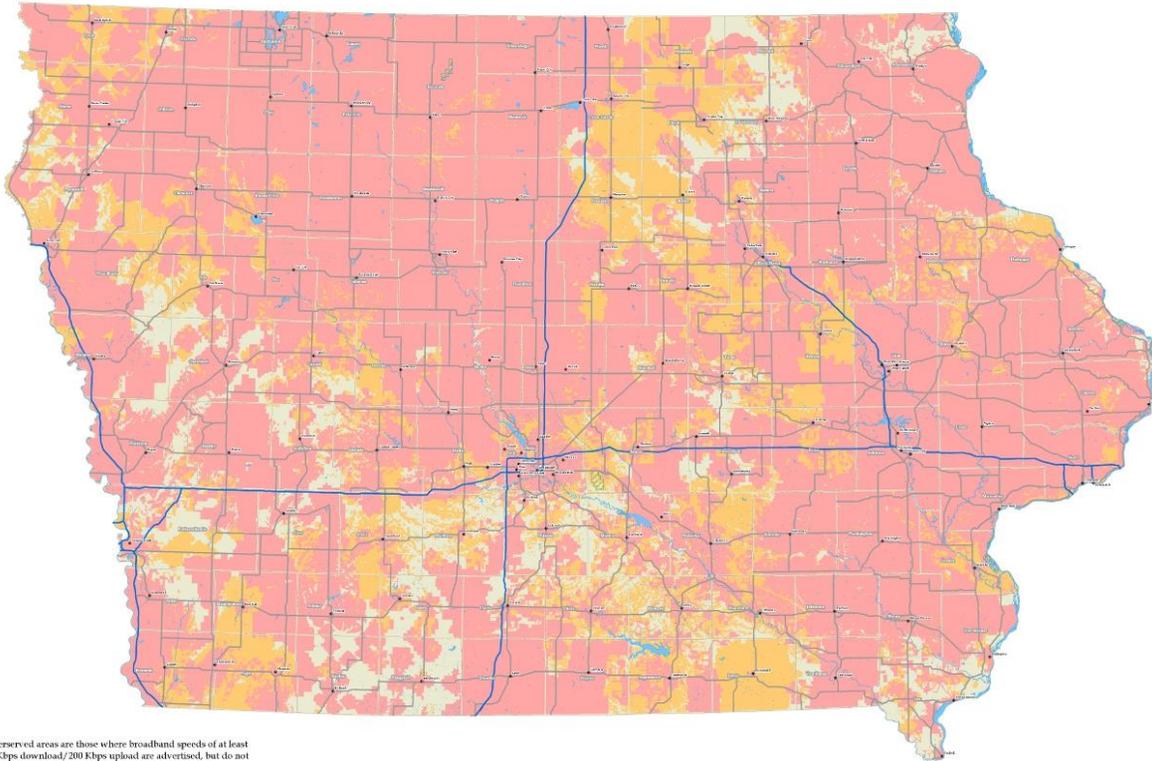
Rural areas also have more limited broadband internet access. These "dead-zones" make it much more difficult for providers to share data and information, access provider dashboards and even remain current with best practices and training opportunities. Through Connect Iowa, a public-private partnership between the Iowa Economic Development Authority and Connected Nation, the State is working to bring broadband internet access to the entire state of Iowa, especially focusing on the underserved areas of the state. While these efforts are underway, workgroup members, particularly those in the LTCSS integration workgroup, identified this lack of reliable access as a barrier to coordinating care. The following map identifies geographic coverage areas.

**Figure 11: Map of Broadband Service Inventory**



**Underserved Broadband Service Inventory for the State of Iowa  
by Terrestrial, Non-Mobile Broadband Service**

Submit questions or recommended changes to: [maps@connectiowa.org](mailto:maps@connectiowa.org)



Underserved areas are those where broadband speeds of at least 768 Kbps download/200 Kbps upload are advertised, but do not meet the 3 Mbps download/768 Kbps upload threshold.

As required by the US Department of Commerce's State Broadband Initiative, if broadband service is available to at least one household in a census block, then for mapping purposes, that census block is reported to have some level of broadband availability. As such, broadband availability at an exact address location cannot be guaranteed. Providers supplying more specific data than census block are displayed in red.

This map represents areas of broadband service availability determined by ongoing, in-depth inclusion analysis of provider networks and accommodations for the impact of external factors on service quality. Satellite broadband services may also be available.

Map users are encouraged to participate in improving broadband data granularity through data validation and field testing efforts. Learn more about this and other broadband mapping facts at [www.connectiowa.org](http://www.connectiowa.org).

**Symbology**

- City
- Interstate
- US Road
- County Boundary
- Water
- National and State Lands
- Broadband Service of at Least 3 Mbps Download/768 Kbps Upload
- Underserved Areas
- Unserved Areas

BETA Version  
Updated October 1, 2013

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**Out-of-Pocket Costs as a Barrier to Seeking Care**

While Iowa has a lower uninsured rate than the national average, as noted above, Iowans do incur higher out of pocket costs than the national average. From 2010 to 2011, the Iowa average out of pocket spending amount was \$3,513, compared to a national average of \$3,456. Similarly, the Iowa average percentage of high burden spending amount was 20.4% compared to a national average of 18.3%. Despite this, a smaller percentage of Iowans (6.4%) delay care due to cost compared to the national average (10.9%). A concern in the state is that as medical costs continue to rise and consume an increasing share of Iowan's income that more people will delay or not seek needed care.<sup>48</sup>

## Workforce Needs

Every two years the Iowa Workforce Development provides projections of expected growth or decline among occupations. Health care occupations accounted for seven of the top 20 occupations most likely to grow between 2004 and 2014. The list included ambulatory health care services, social assistance, registered nurses, nursing aides and orderlies and attendants. In 2007, the Health and Long-Term Care Workforce submitted a report to the Iowa General Assembly that included information on the scope of the problem as well as recommendations on how to address the challenge. One of the key themes is that recruitment and retention is particularly challenging in rural areas, across all provider types.<sup>49</sup>

This section provides an overview of workforce challenges. Section 11 provides an overview of efforts underway to address workforce challenges. These efforts include changes to medical school curriculum and programs to support new physicians entering primary care specialties and in rural areas.

### Medical Providers

Iowa is unique in that it has tools in place to continuously inventory major categories of its health professions workforce, including the physician workforce. The Iowa Physician Information System is a computer-based tracking system that has tracked Iowa's physician population for the past 30 years, allowing highly precise trending and reliable forecasting. The data system was established by the Office of Statewide Clinical Education Programs (OSCEP) in the UI College of Medicine in 1977. OSCEP continues to operate the database today.

During the stakeholder meetings, several people indicated that the aging workforce is cause for concern. Interestingly, the OSCEP data (from 2005) does not bear this out. In fact, Iowa's physician population is younger than the nation's physician population.<sup>50</sup>

**Table 13: Age Distribution of the Physician Workforce**

Age Distribution of Active Physician Workforce		
	Iowa	U.S.
<b>Physicians 55 and older</b>	25%	36%
Physicians 65 and older	4%	19%

Source: *Report of the Task Force on The Iowa Physician Workforce*. January 2007.

The number of providers in Iowa is increasing at a higher rate than the increase in total population. However, this growth is not occurring consistently across the state. In 2007, the Task Force on the Iowa Physician Workforce concluded that:

Given the pattern of increasing supply during the past 29 years, it is reasonable to project that physician supply will continue to grow at a faster rate than Iowa's general population. However, general statements such as these do not address the supply dynamics for specific specialties, especially those that have a small

base in the current physician population. While the projections for the total physician and primary care physician populations are favorable, strategies are needed to address the supply of non-primary care physicians.

In particular, there is a shortage of psychiatrists in the State. Although the data are somewhat old, results of a 2006 comprehensive examination of Iowa's mental health workforces conducted by the Center for Health Workforce Planning, found that Iowa ranks 47<sup>th</sup> among states for psychiatrists per 100,000.<sup>51</sup> For the period of 1995 – 2005, there were marginally fewer psychiatrists with net losses (in total number) for three of the five years from 2000 to 2005. During this same period there was a modest increase in the Iowa population. Thus, by definition, the supply trend line in psychiatry is one of decline. Iowa has half the number of psychiatrists per 100,000 population (7.6) compared to the national figure (15.8). Moreover, in 2005 just 32 of Iowa's 99 counties were home to at least one psychiatrist, although additional sites receive direct services from some of Iowa's psychiatrists who conduct outreach clinics as visiting consultants.

Consistent with the fact that providers are younger than the national average, only about a quarter of the annual attrition in Iowa's physician population is due to retirements. Relocation to other states is the principal reason for attrition from the supply of Iowa physicians, accounting for more than 60% of the annual loss.

Several stakeholders also indicated that many individuals complete their residency training in Iowa but leave the State after their training is complete. Data from the Iowa Health Professions Tracking Center at the University of Iowa Carver College of Medicine support this assertion. In 2011, there were a total of 123 graduates from selected residency programs in family medicine, internal medicine, pediatrics, general surgery and obstetrics/gynecology.<sup>52</sup> Of these graduates, 77 entered practice, 39 were continuing their training and seven others were doing temporary work or graduating late. Of these 77 new graduates:

- 51% were entering a non-Iowa practice; and
- Only 32% (a total of 12 providers) of these entering an Iowa practice were doing so in a community with fewer than 25,000 residents.

### Physician Assistants and Advanced Practice Nurses

In Iowa there are more physician assistants per 100,000 population than there is nationally (31.7 as compared to 27.0). However, there are far fewer nurse practitioners: only 43.4 per 100,000 population while there are 57.8 per 100,000 nationally.<sup>53</sup> Increasing the number of nurse practitioners represents an important opportunity since Iowa has a scope of practice law that supports individual decision-making authority for nurse practitioners. It is one of 24 states that do not require physician involvement in diagnosis and treatment and one of 32 states that does not require physician involvement in prescribing medications.

In addition to monitoring physicians, the Iowa Health Professions Tracking Center also monitors the number of and location of pharmacists, dentists, nurse practitioners

(advanced practice nurses (APN)) and physician assistants. The majority of APNs are family NPs, RN Anesthetists and Pediatric NPs. As with the physicians, there is uneven geographic distribution with nearly 60% practicing in communities with more than 50,000 residents. In 2011, fewer than 500 of the 1,417 APNs were practicing in communities with fewer than 50,000 people.<sup>54</sup>

## Nursing

There is a well-documented shortage of nurses nationally and in Iowa the driving forces behind supply and demand reflect many of the national trends. There are also several unique factors, including:<sup>55</sup>

- The economic challenges of a rural state with small, independent farming communities;
- A declining population between the ages of 18 and 24;
- A relatively high percentage of elderly Iowans with multi-system and accessibility needs;
- A growing population of new Iowans employed in low income jobs who are not enrolling in nursing programs;
- A significant tuition and loan burden for students in pre- and post-licensure education programs;
- Low pay related to low provider reimbursement rates in Iowa. For example, The United States Department of Labor ranks Iowa as the lowest paying state for RNs. In 2004 a registered nurse in Iowa earned \$9,000 less than the national average and \$11,000 less than an RN working in the border state of Minnesota. In 2006, according to the Iowa Nurse Taskforce, the national mean average wage for registered nurses was \$57,280, while in Iowa it was \$47,030;
- Departure of newly licensed registered nurses in pursuit of higher wages; and
- Aggressive recruitment of students and nurses by states experiencing acute shortages that pay more.

In Iowa, the vacancy rate for nurses (RNs and LPNs) and for certified nursing assistants (CNAs) in nursing facilities is similar to the national average. There are slightly lower turn-over rates than nationally.<sup>56</sup>

## Pharmacists

Nationally, demand for pharmacists is expected to increase through 2020.<sup>57</sup> HRSA has studied the supply of pharmacists and noted that there is a weak pool of applicants to pharmacy education programs and an increase in the percentage of women who are entering the field. Women across all occupations, including pharmacy, are more likely to work part-time or three-quarters time than men. In Iowa, the Iowa Pharmacy Association reports that pharmacies are closing across the State and the Iowa Hospital Association reports that pharmacists are among the top professions with vacancies in Iowa hospitals.

## Mental Health Providers

In addition to the psychiatric shortages addressed above, there is also a shortage of psychologists, marital and family counselors and mental health counselors, particularly in the southern two tiers of counties and the northeast quadrant of the State. The professions serving the mental health needs of Iowans had the highest combined percentage of licensed professionals age 55 and older and in 2006 the Center for Health Workforce Planning's comprehensive assessment of the mental health workforce reported that Iowa ranks 46<sup>th</sup> for psychologists per 100,000.<sup>58</sup> These issues of provider shortages and aging provider workforce may be exacerbated by the enrollment of adults into the Iowa Health and Wellness Plan as many of these new enrollees will have significant behavioral health needs that have gone un-treated for many years.

As with other health care professions, the most rural areas face the greatest shortages of mental health providers. The southern two tiers of counties and the northeast quadrant face the most acute shortages; the need for child and adolescent psychiatrists is most acute in western Iowa.

## Direct Care

There are currently more than 70,000 direct-care workers that provide more than 80% of the hands-on care and support to children and adults needing long term supports and services that help Iowans maximize their independence, their health and their quality of life. The Iowa CareGivers Association estimates Iowa will need 12,000 more direct-care workers between 2008 and 2018.<sup>59</sup> This increasing demand is concurrent with declines in the number of women aged 25 – 44, the traditional source of direct-care workers.

Direct care workers are among the lowest paid of health care workers and nearly 25% reported not being covered by health insurance from their employer. Not surprisingly, it is difficult to hire and retain direct care workers and the annual turn-over rate among nursing assistants, home health aides and person care attendants range from 40 to 100%.<sup>60</sup> This turn-over is very disruptive for patients and directly affects the quality of care provided. Iowa also loses many health care workers to other states where the pay is higher.

## Dentists in Iowa

As of December 2011, Iowa had 1,506 dentists. For comparison, in 2011 in Iowa there were 5,584 physicians, 2,828 pharmacists, 1,417 nurse practitioners, and 722 physician assistants. Of the 1,506 dentists, 1,366 were in private practice.<sup>61</sup> Other relatively large categories include 81 in dental schools or research institutions, 39 in community health or local government. The remainder work in other public health entities. During 2011, 59 dentists terminated their practice. The majority of dentists specialized in general practice, with 1,131 (79%) reporting this specialization. Only 44 dentists reported specializing in pediatric dentistry. Approximately, 78.6% of dentists are under 60 years old, but over half are over 50 years old.

The average distance to a general dentist in the state is 8.5 miles. The overall dentist to population ratio is 2,033:1 and the overall population to general dentist ratio is 2,242:1. For comparison purposes, the report *Oral Health In America: A report of the Surgeon General* cites a 1999 Health Resources and Services Administration report that estimated the national population to dentist ratio at the time at 1,700:1, a significantly lower ration that the ratio in Iowa.<sup>62</sup> The data suggest that the oral health workforce in Iowa is not sufficient, and with over 50% of current dentists over age 50, the need for workforce efforts in this area is likely to grow in upcoming years.

### County Perspective of Needs

In its 2011 Community Health Needs Assessment and Health Improvement Plan, the IDPH defined the health needs of Iowans in accordance with the Healthy People 2020's categorizations in order to be compatible with national health planning objectives as well as define which Iowan health needs are most acute and widespread. As is shown in the table below, access to health services has been identified as the leading health need across Iowa counties.

**Table 14: County Needs by Healthy People 2020 Category**

Health People 2020 Category	Number of Identifying Counties	% of Identifying Counties	IDPH Focus Area
Access to Health Services	92	93%	Health Infrastructure
Maternal, Infant, and Child Health	87	88%	Healthy Behaviors
Environmental Health	83	84%	Environmental Health
Injury and Violence Prevention	79	80%	Prevent Injuries
Nutrition and Weight Status	77	78%	Healthy Behaviors
Immunizations and Infectious Disease	72	73%	Prevent Epidemics
Preparedness	66	67%	Emergency Response
Mental Health and Mental Disorders	61	62%	Healthy Behaviors
Substance Abuse	58	59%	Healthy Behaviors
Chronic Disease	48	48%	Healthy Behaviors

Source: Iowa Department of Public Health, *Understanding Community Health Needs in Iowa, Understanding Community Health Needs Assessment and Health Improvement Plan, 2010-2011.*

IDPH's 2011 Community Health Needs Assessment and Health Improvement Plan also provides detailed information on specific needs within the larger categories and focus areas reported above.

**Table 15: Needs by Prevalence**

<b>Needs by Prevalence</b>			
<b>Detailed Need</b>	<b>Number of Identifying Counties</b>	<b>% of Identifying Counties</b>	<b>IDPH Focus Area</b>
<b>Obesity and Overweight</b>	74	74.7%	Healthy Behaviors
<b>Access to Transportation</b>	41	41.4%	Health Infrastructure
<b>Water Quality</b>	41	41.4%	Environmental Health
<b>Motor Vehicle Accident Prevention</b>	36	36.4%	Prevent Injuries
<b>Access to Mental Health Services</b>	35	35.4%	Health Infrastructure
<b>Cancer</b>	35	35.4%	Healthy Behaviors
<b>Youth Substance Abuse</b>	32	32.3%	Healthy Behaviors
<b>Educational and Community Based Programs</b>	32	32.3%	Health Infrastructure
<b>Lead Poisoning and Screening</b>	32	32.3%	Environmental Health
<b>HIV/STD Prevention, Screening, and Treatment</b>	31	31.3%	Prevent Epidemics
<b>Emergency Response: Communication and Network</b>	30	30.3%	<b>Emergency Response</b>
<b>Family Planning</b>	29	29.3%	
<b>Heart Disease and Stroke</b>	28	28.3%	<b>Healthy Behaviors</b>
<b>Social Determinants of Health</b>	27	27.3%	<b>Health Infrastructure</b>
<b>Tobacco</b>	27	27.3%	<b>Healthy Behaviors</b>
<b>General Mental Health</b>	25	25.3%	<b>Healthy Behaviors</b>
<b>Access to Health Insurance</b>	23	23.2%	<b>Health Infrastructure</b>
<b>Childhood Immunizations</b>	23	23.2%	<b>Prevent Epidemics</b>
<b>Child Abuse Prevention and Child Safety</b>	23	23.2%	<b>Injury Prevention</b>
<b>Emergency Response: Volunteers and Personnel</b>	23	23.2%	<b>Emergency Response</b>
<b>Suicide Prevention</b>	22	22.2%	<b>Injury Prevention</b>
<b>Economic Barriers</b>	21	21.2%	<b>Health Infrastructure</b>

Source: Iowa Department of Public Health, *Understanding Community Health Needs in Iowa, Understanding Community Health Needs Assessment and Health Improvement Plan, 2010-2011*.

### **LTCSS Issues and Barriers**

Many of the barriers to improving the quality of LTCSS in Iowa are the same as the barriers already identified, including the rural nature of the state, shortage of providers, particularly in the rural areas and internet connectivity challenges. Provider shortages and long travel distances can pose even greater challenges in providing home and community based services which are needed frequently, sometimes even daily.

LTCSS providers also face additional challenges in adopting electronic health records. The Electronic Health Records (HER) incentive programs did not include support for LTCSS providers, meaning adopt rates are even lower. Moreover, many providers are small and not affiliated with larger corporate entities and lack the financial resources to invest in EHRs. Finally, the sharing of care plans and other medical information is additionally challenging because so much care is provided by family members and friends.

Another barrier to care for individuals wanting to remain in their homes and communities is the lack of supportive services (services are often tied to the benefit structure of each waiver and do not always accommodate the needs of all waiver enrollees) and the program waitlists.

During the workgroup sessions, several members also indicated that the aging infrastructure of many LTC facilities is a concern, as is too much emphasis on institutional care. The IME is taking steps to increase the use of home and community based services and is the recipient of a Balancing Incentive Program grant.

### **Behavioral Health Issues and Barriers**

Iowa has consistently ranked among the 10 States with the lowest unmet need for drug treatment for the population age 12 and older, as well as for the population age 12 to 17. For each of the four age group categories (12+, 12 – 17, 18 – 25 and 26+) Iowa has lower than the national average rates for unmet need for drug treatment. Conversely, the rates of alcohol dependence and unmet need for alcohol treatment have consistently been at or above the national rate and in 2005-2006 were among the highest in the country for all population groups except for those aged 26 and older.<sup>63</sup>

The State's own analysis substantiates the needs identified in the national survey. Approximately 60% of Iowa's counties cited access to greater mental health and substance abuse services as a need in the IDPH's Community Health Needs Assessment and Health Improvement Plan.

**Table 16: County Mental Health and Substance Abuse Needs**

Category & Need Detail for Mental Health and Substance Abuse			
Category	Need	# of Identifying Counties	% of Identifying Counties
<b>Mental</b>	<b>Overall Mental health Need</b>	<b>61</b>	<b>61.6%</b>
	Access to Mental Health Services	35	35.4%
	General Mental Health	25	25.3%
	Suicide Prevention	22	22.2%
	Youth Mental health	9	9.1%
<b>Substance Abuse</b>	<b>Overall Substance Abuse Need</b>	<b>58</b>	<b>58.6%</b>
	General Substance Abuse	19	19.2%
	Youth Substance Abuse	32	32.3%
	Youth Substance Abuse-Alcohol	18	18.2%
	Youth Substance Abuse-All	13	13.1%
	Youth Substance Abuse-Drugs	3	3.0%

Iowa, like many other states, is increasingly utilizing telehealth services to increase access to benefits not often available in rural and under-served areas. Because of the nature of the capitated behavioral health program the State is able to track its use for behavioral health centers. The data show that the number of Medicaid members using telehealth through the BHO has doubled. In 2009, 261 unique members in the statewide managed behavioral health program used telehealth services; in 2010, 575 unique members utilized telehealth services; and in 2011, 1,168 unique members utilized telehealth services.

### **Siloed Delivery Systems and Lack of Information**

While Iowa ranks highly on the quality and value of health care relative to other states, the health care system is siloed and not integrated within services (for example primary care providers are not always aware of the specialty services their patients are accessing). The system is also not integrated across medical, behavioral and LTCSS. These different, separate systems create even more barriers for Medicaid members seeking coordinated care because these individuals with high needs interact with multiple systems – behavioral health, physical health and LTCSS. Frequently individuals receiving LTCSS will have multiple care coordinators or care managers, none of whom collaborate with one another. Through the statewide ACO model, care will be more coordinated, patients will be supported in navigating multiple systems including non-health systems, and providers will appreciate access to actionable and timely data. After Wellmark implemented its ACOs, providers frequently remarked that it was incredibly helpful to have access to data and services being provided by other practitioners. IME's intent is to implement the same tools as Wellmark to provide timely, actionable data which will drive consistency and improvement across payers.

## 4. Current Health Care Cost Performance Trends and Factors Affecting Cost Trends (Responds to Question 8)

### Overall Costs

As can be seen in the table below, there are two health care services in which Iowa spends more per person than the national average: hospital services and other services (this includes both commercial and public program expenditures). While Iowans spend less per person than the national average on physician and clinical services and other services, the hospital and other services are proportionately larger enough to make the overall expenditures higher than the national average.

**Table 17: Health Care Spending Per Person**

Health care spending per person by type of service, 2009		
All services	\$6,921	\$6,815
Hospital	\$2,713	\$2,475
Physician and Clinical	\$1,381	\$1,650
Other Professional	\$214	\$218
Other Services	\$2,613	\$2,211

Source: NORC technical assistance team for the State Innovation Models (SIM) project. *Benchmark State Profile Report for Iowa*. Data from CMS Office of the Actuary, Health Expenditures by State of Residence. Other Services includes the following: Dental Services; Home Health Care; Prescription Drugs; Durable Medical Products; Nursing Home Care; Other Health, Residential, and Personal Care.

For all types of private market coverage, including private insurance, employer sponsored insurance, and individual insurance, Iowans spend less in average premiums than national averages.

**Table 18: Private Market Costs**

Measure	Iowa	United States
<b>Private Market</b>		
<b>Average cost per person with private insurance</b>		
Statewide	\$3,155	\$3,268
<b>Average premium in the employer sponsored market, 2011</b>		
Single	\$4,742	\$5,222
Family	\$13,030	\$15,022
<b>Average premium in the individual insurance market, 2010</b>		
Adults	\$2,520	\$2,580

Source: NORC technical assistance team for the State Innovation Models (SIM) project. *Benchmark State Profile Report for Iowa*. Average cost data from *Commonwealth Fund Local Scorecard* analysis of Thomson Reuters MarketScan database, statewide measure is an average weighted by population. The measure is adjusted for age, sex, and regional wage difference. As a result, it illustrates variation driven primarily by price rather than population health. Measure refers to non-elderly population only. Average premium data from Medical Expenditure Panel Survey-Insurance Component, numbers reflect total premiums paid by employers and employees. Average premium in individual market from Kaiser State Health Facts analysis of data from the Mark Farrah Associates.

For public programs, Iowa spends less per enrollee than the national average. However, Iowa's spending per enrollee for aged and disabled populations is higher than national averages. Moreover, as demonstrated below, there is great regional variation in Medicaid expenditures. With the ACOs, the State has a goal of assessing why there might be regional differences (for example, the cost-based reimbursement structure, more people traveling out-of-state for care, or over-supply of some services) and then working with the ACO partners to develop interventions that are grounded in regional strengths.

**Table 19: Spending in Public Programs**

Measure	Iowa	United States
<b>Public Programs</b>		
<b>Medicare spending per enrollee, FY 2009</b>		
	\$7,987	\$9,477
<b>Medicaid spending per enrollee, FY 2009</b>		
Total	\$5,438	\$5,535
Aged	\$14,207	\$13,186
Disabled	\$18,236	\$15,453
Adults	\$2,109	\$2,926
Children	\$1,993	\$2,313

Source: NORC technical assistance team for the State Innovation Models (SIM) project. *Benchmark State Profile Report for Iowa*. Data from Dartmouth Atlas of Healthcare and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on the FY 2009 Medicaid Statistical Information Statistics (MSIS) and 2012 CMS-64 reports.

Iowa health carriers list increasing inpatient hospital costs, other costs, and physician costs as the top three drivers responsible for increasing medical cost trends.<sup>64</sup> While prescription drugs were listed as the 4<sup>th</sup> highest driver of medical costs, prescription drugs costs actually decreased from 2011 to 2012.

## Medicaid Costs

In Iowa's Medicaid program, recent growth of per member cost has been very low. Individual average per member per month (PMPM) claim costs went from \$97.89 in 2005 to \$159.83 in 2011, which is a 63.3% increase in PMPM claim costs over a 7-year period.<sup>65</sup> During State Fiscal Year (SFY) 2011, there was a 0.71% increase in growth per member, with a higher 1.79% increase in growth during SFY2012.<sup>66</sup> The State estimates that this low growth rate will continue.

However, merely slowing the growth rate of the cost per member is not sufficient. With the Iowa Health and Wellness Plan implementation and the premium supports available through the Exchange, the State is likely to experience a "woodwork" or "welcome mat" effect, whereby many Iowans who had been eligible for Medicaid but never enrolled will apply and begin receiving benefits. For these individuals, Iowa's Federal Medicaid Assistance Percentage (FMAP) will be the standard FMAP and not the enhanced FMAP available for newly eligible individuals.

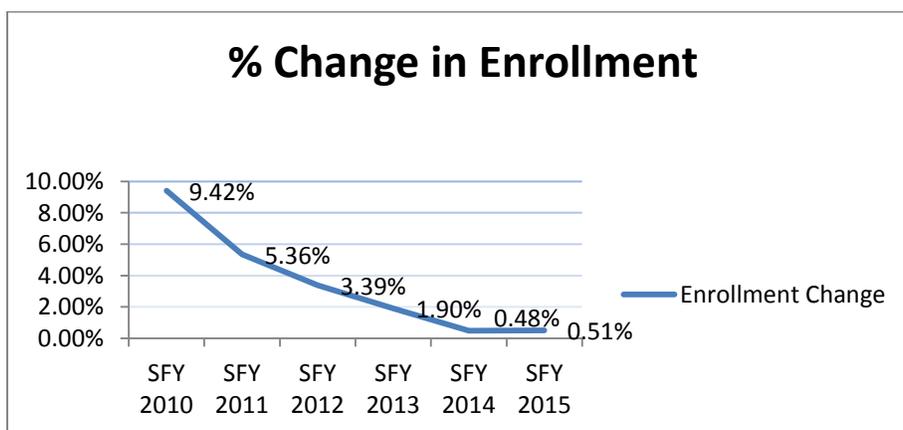
Compounding this is the fact that Iowa's FMAP has been declining rapidly as the economy has improved in Iowa relative to other states:

- SFY 2010: 72.09% (includes ARRA increase)
- SFY 2011: 70.64% (includes ARRA increase)
- SFY 2012: 61.19%
- SFY 2013: 59.87%
- SFY 2014: 58.35%
- SFY 2015: 56.14%

The State estimates that each one percentage point change equals about \$35 million. This confluence of increased enrollment (even at smaller rates), increase costs (even at small rates), aging population, and decreased FMAP makes it imperative that the State develop a system that will focus on value and not volume.

### Enrollment Growth

Growing enrollment is an important factor in the overall increase in the cost of the program. During State Fiscal Year 2013, the unduplicated Medicaid enrollment was 631,479, with 312,438 adults and 319,041 children.<sup>67</sup> There were 420,204 Medicaid members enrolled in State Fiscal Year (SFY) 2012. There was a 3.39% increase in enrollment from SFY 2011 to SFY 2012 and only a 1.90% growth rate from SFY 2012 to SFY 2013. As demonstrated below in Figure 12, these more recent increases are smaller than the increases for years prior. The State projects that there will continue to be enrollment growth but at lower rates: 1.90% in SFY 2013, 0.48% in SFY 2014, and 0.51% in SFY 2015.<sup>68</sup>



It is important to note that these estimates do not include those who enroll due to the "woodwork" effect so the projected enrollment growth may be an under-estimate. Forecasting the magnitude of these new enrollments is very challenging but the State will continue to refine these estimates as enrollment data become available in 2014.

Historically, enrollment growth is driven by children. In more recent years, the children's growth rate has steadily declined and the State estimates that such growth will continue to slow over the next three fiscal years.<sup>69</sup>

While some children have high needs and are, therefore, costly to treat, most (nearly seven in ten) of those children not receiving LTCSS (including waiver services) are either non-users or healthy. About 11.6% of children who are classified as complex or simple chronic account for about 46.0% of costs for children. Overall, the average cost per child is lower than for any other group.

### Figure 13: Pediatric Population and Cost Distribution

Population distribution and cost distribution for pediatric members



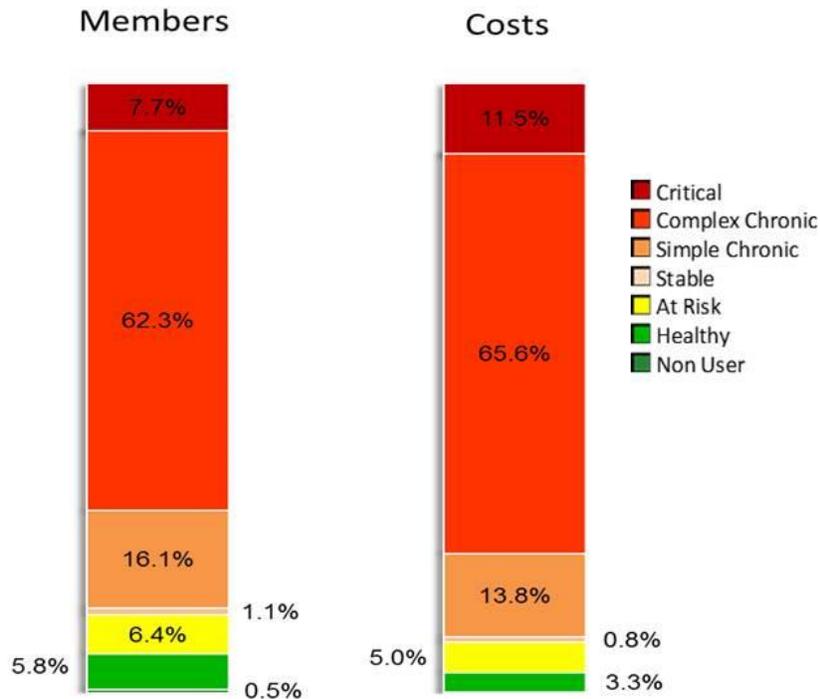
Based on CY 2012 Iowa Medicaid members age 18 or younger excluding LTC, Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network & Iowa Care

### Long Term Care Supports and Services Costs

Like many states, children make up the majority of Medicaid members but they are not the most costly.<sup>70</sup> It is a smaller portion of the Medicaid population, the 19% with disabilities, that consumes 50% of Iowa's Medicaid costs. In contrast with other cohorts, in which there are significant numbers of non-users, there are very few non-users among the population receiving LTCSS. Also, the distribution is much more aligned, 78% are classified as simple or complex chronic and they account for 79% of the expenditures.

## Figure 14: Population and Cost Distribution of Individuals Receiving LTCSS

Population distribution and cost distribution for members receiving Institutional Long Term Care and Waiver Services



Based on CY 2012 Iowa Medicaid excluding Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network & Iowa Care

Many of those with disabilities are dually eligible for Medicaid and Medicare. Iowa has approximately 70,000 dual eligibles enrolled in its Medicaid program, more than half of whom have a serious mental illness, and this group costs more than \$1 billion annually. Iowa was awarded a Financial Alignment Demonstration Proposal for Medicare-Medicaid that will enable the State to receive a share of Medicare savings if it incorporates dual eligible individuals in the home health and other health management programs that lead to savings. The State recognizes the importance of this initiative but has been primarily focused on the SIM design work, the Balancing Incentive Payment Program, and the Iowa Health and Wellness Plan. As a result, only limited forward progress has occurred.<sup>71</sup>

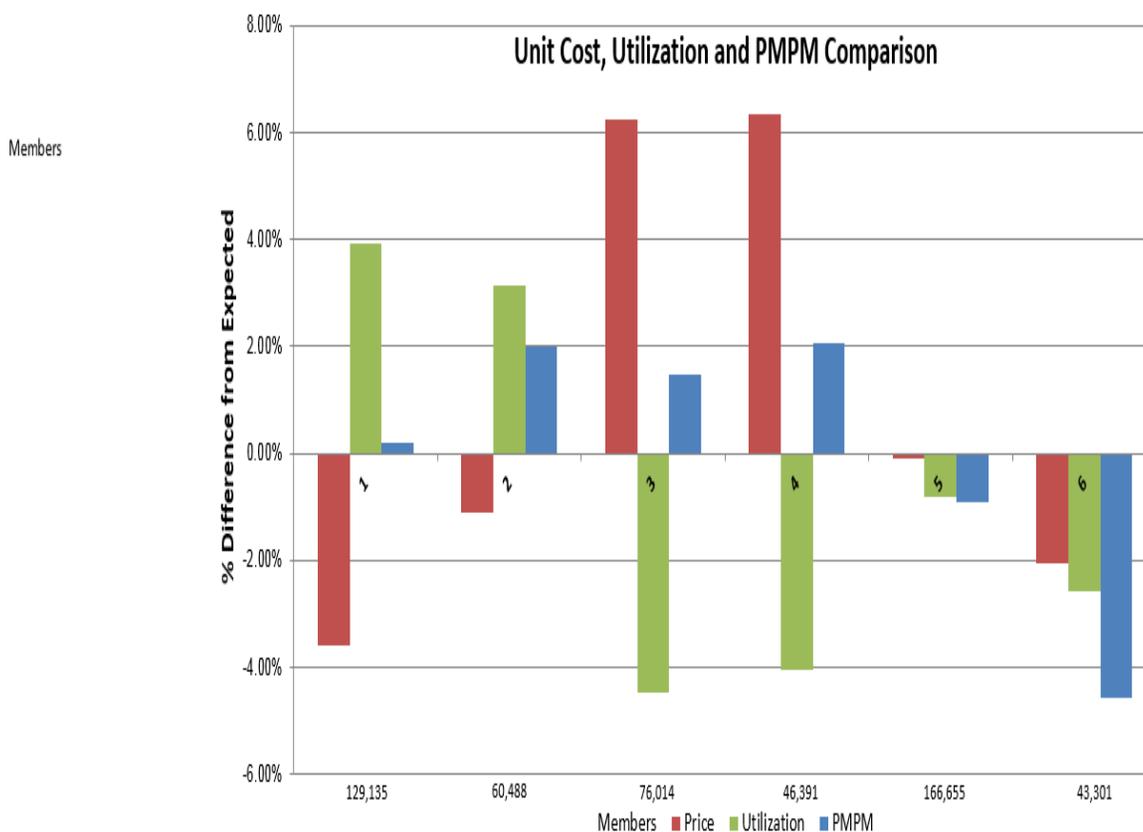
In FY 2012, Iowa spent about \$1.5 billion on long term supports and services—more than half of total Medicaid expenditures—for the approximately 12,000 Medicaid enrollees in nursing facilities and the approximately 25,500 Medicaid enrollees receiving care through a Home and Community Based Services Waiver.<sup>72</sup> Iowa will use its recently approved Balancing Incentive Program Plan (BIPP), which supplies \$17.8 million in federal incentives, to reduce long term care costs by equalizing expenditures between facility-based and home and community based services.<sup>73</sup> Iowa expects to save \$1 million in SFY14 and \$1.1 million in SFY15 as a result of the BIPP.<sup>74</sup> The BIPP has



Member-based expected values for this analysis were created by computing the average spent and utilization for each clinical risk group and severity category for each potential Medicaid ACO region. The analysis at a regional level allows the State to identify delivery system and cost saving opportunities specific to each potential ACO region. Because communities differ, by taking a regional approach, the ACOs can capitalize on the strengths of each community and take steps to address weaknesses and areas where additional support is needed.

In the figure below, the blue bar represents total cost of care measured on a PMPM basis. A bar above the line demonstrates performance that is higher than expected; below the line is less than expected on a risk adjusted basis. The red bar—price—demonstrates variation in unit prices paid to those providing care to Iowa Medicaid enrollees; the green bar demonstrates variation in utilization by region. By looking at this chart the State can ascertain whether unit cost, utilization or both are driving total cost of care performance.

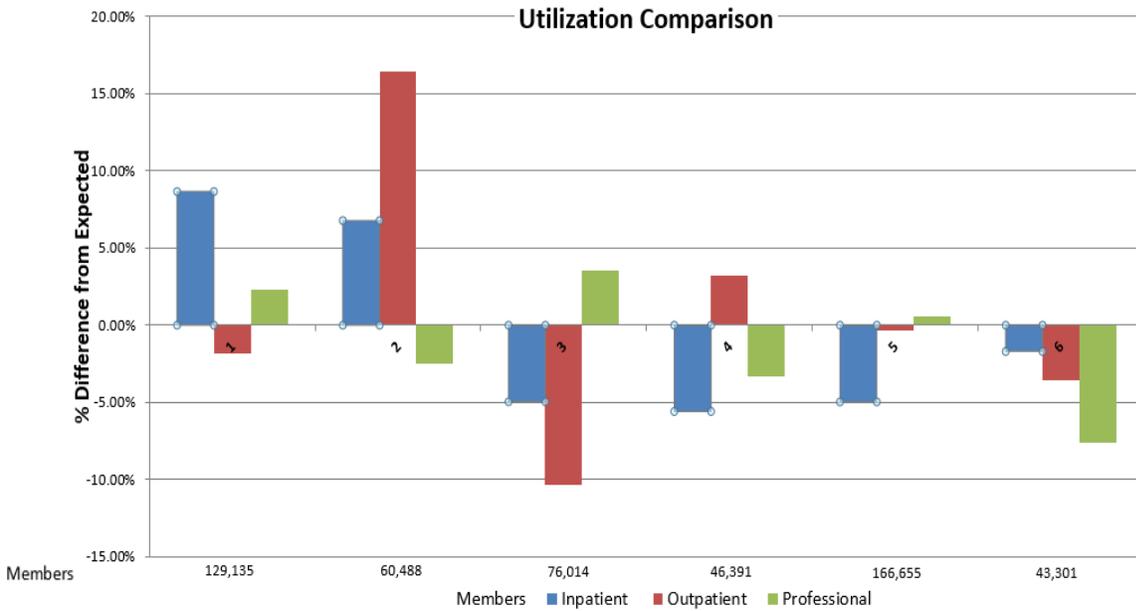
**Figure 16: Risk Adjusted Total Cost of Care Comparison for Members Within Regions by Place of Service (CY 2012)**



Analysis of CY 2012 Iowa Medicaid data. The following populations were excluded: LTC (institutional), Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare. Proposed Region map depicts counties in each region.

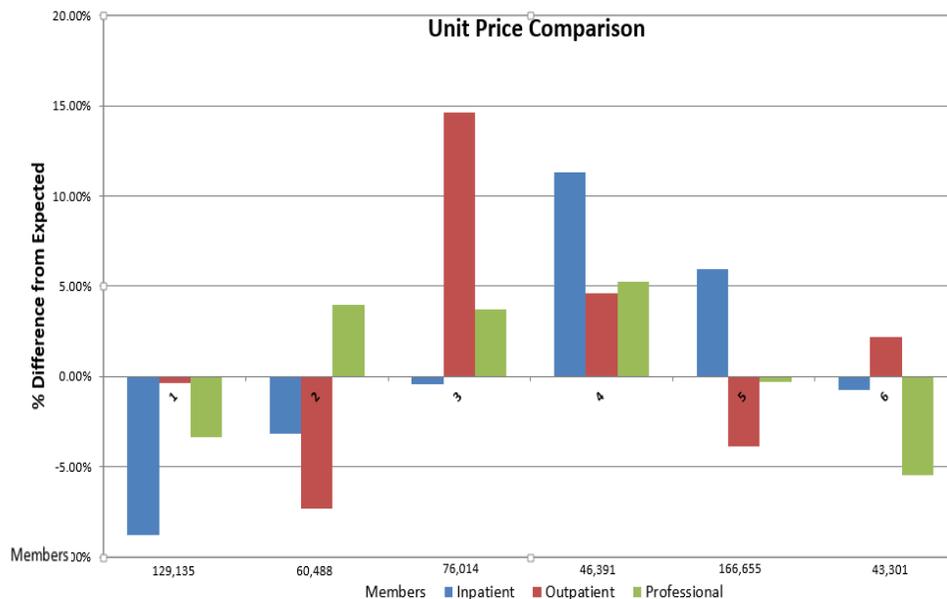
The subsequent charts (utilization comparison and unit price comparison) break down each of these drivers by their core components (inpatient, outpatient and professional). This analysis reveals which service category is driving overall utilization and unit cost variation. For example, the utilization chart shows that Region 2 has higher than expected inpatient and outpatient utilization and lower than expected professional utilization while Region 3 has lower than expected inpatient and outpatient utilization and higher than expected professional utilization.

**Figure 17: Risk Adjusted Utilization Comparison for Members Within Regions by Place of Service (CY 2012)**



Analysis of CY 2012 Iowa Medicaid data. The following populations were excluded: LTC (institutional), Waiver, Dual Eligibles, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare.

**Figure 18: Risk Adjusted Unit Price Comparison for Members Within Regions by Place of Service (CY 2012)**



Analysis of CY 2012 Iowa Medicaid data. The following populations were excluded: LTC (institutional), Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare. Proposed Region map depicts counties in each region.

The remaining three charts demonstrate variation by region in utilization of potentially preventable events (PPE). These are:

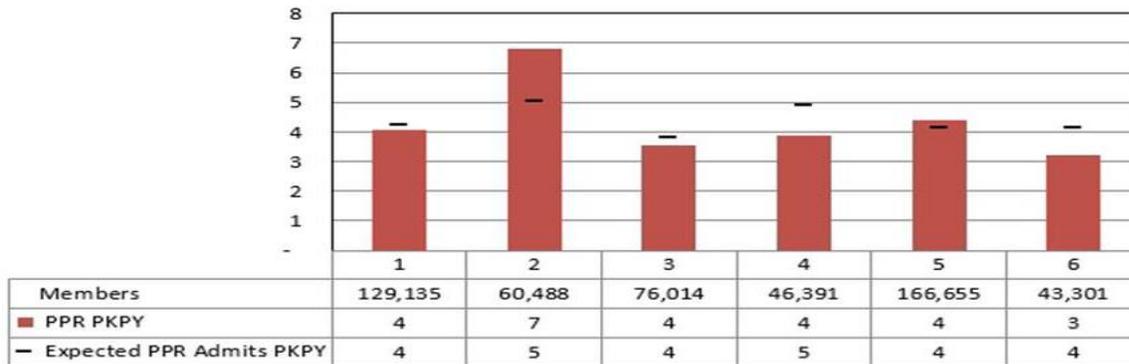
- Potentially preventable readmissions (PPR)
- Potentially preventable Emergency Department visits (PPV)
- Potentially preventable admissions (PPA), which are similar to ambulatory case sensitive conditions

Analysis of these PPEs provides insight on opportunities to improve performance through the identification of potentially avoidable events that may be indicative of system inefficiencies.

Figure 19 below shows the actual PPRs compared to the expected PPRs, calculated in a per member per year risk adjusted by CRGs. Generally, higher than expected PPRs point to system level failure resulting in more readmissions. The system level failures could be, for example, lack of discharge planning or Primary Care Practitioner (PCP) failure to follow-up. Again, in some regions these PPRs are less than expected while in others the rates are higher. This data will enable the regional ACOs to focus their interventions where the rates are higher than expected.

**Figure 19:**

**Potentially Preventable Readmissions  
per 1000 Members per Year by Region CY 2012**

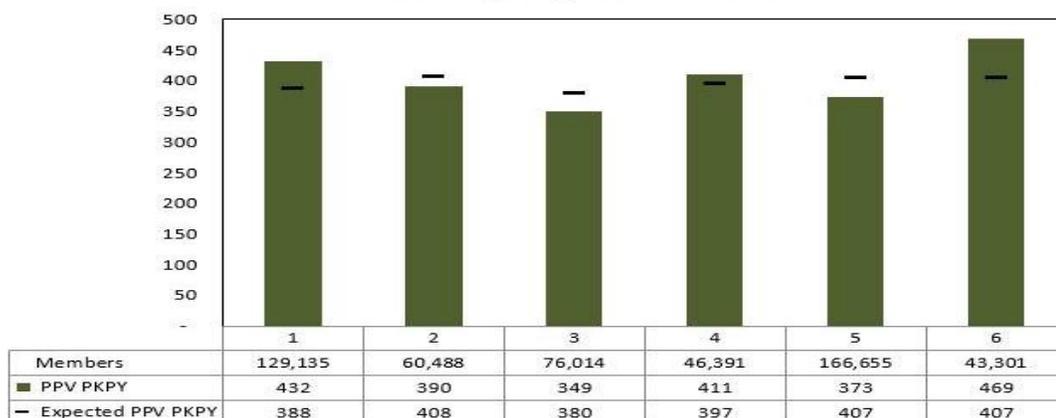


Based on CY 2012 Iowa Medicaid excluding LTC, Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network & Iowa Care

Figure 20 shows “Potentially Preventable ED Visits” compared to expected and shown in a “per member per year” rate that is risk adjusted by CRGs. Generally, higher than expected PPVs point to access issues and lack of PCP management. However, PPVs can also be deflated if facilities in a given region are doing more admissions through the ER. This usually results in higher than expected PPAs (potentially preventable admissions).

**Figure 20:**

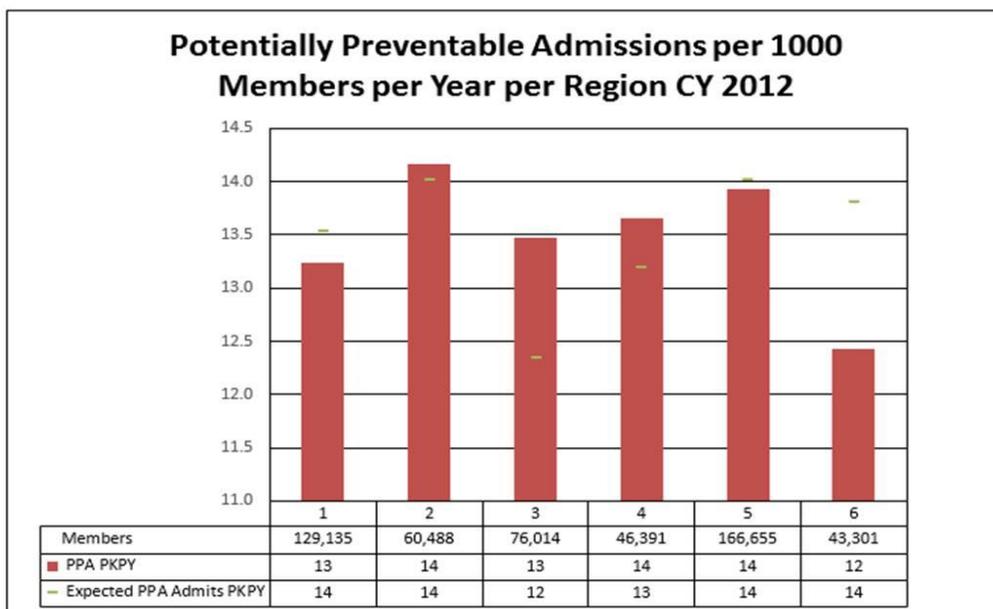
**Potentially Preventable ED Visits per 1000 Members per  
Year by Region CY 2012**



Based on CY 2012 Iowa Medicaid excluding LTC, Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network & Iowa Care

Figure 21 shows potentially preventable admissions by region for CY 2012. Again, each region's actual PPA is compared to the expected PPA when illness burden of the population is considered. Generally, higher than expected PPAs highlight increased need for PCP management of members.

**Figure 21:**



Analysis of CY 2012 Iowa Medicaid data. The following populations were excluded: LTC (institutional), Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare.

Finally, to assess the impact of a PCP that is actively managing their patients, the State analyzed the total cost of care for Medicaid enrollees within each region and segmented by whether the PCP is a director, influencer or contributor (as defined by CMS).

**Figure 22:**

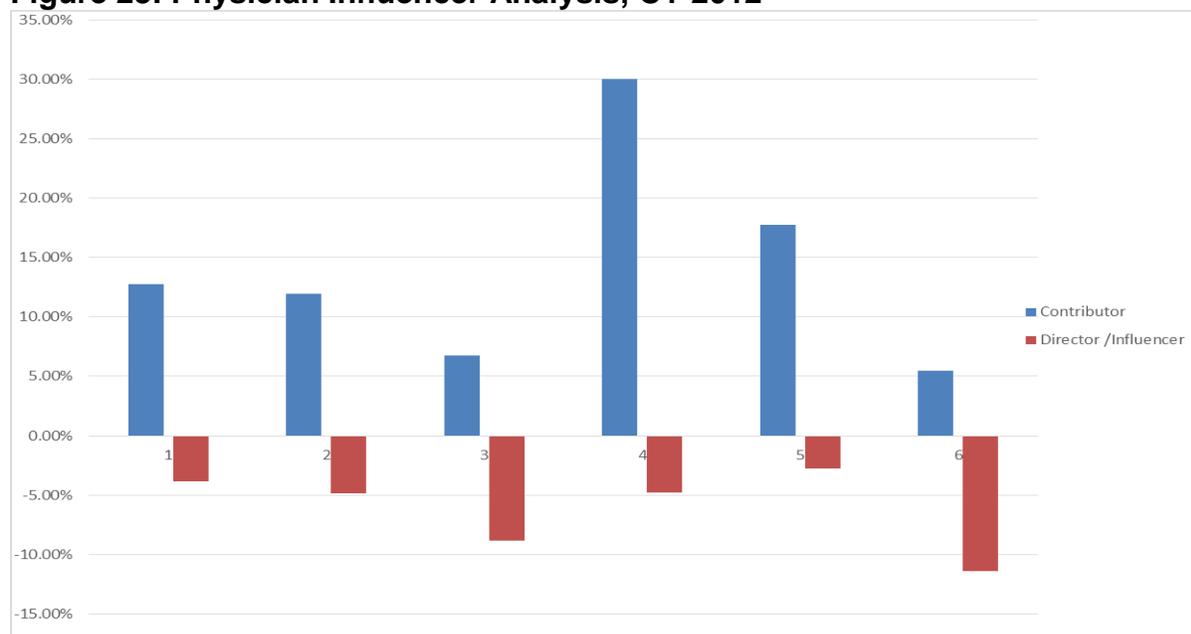
Physician Influence Definitions

<b>Director</b>	The number of visits for E&M services between this provider and patient is more than 35% of the total number of E&M visits for this patient. This is set on office visits only, no inpatient, ER or SNF visits are counted.
<b>Influencer</b>	The total paid amount for this provider is more than 20% of the total allowed for all provider services for this patient
<b>Contributor</b>	All other eligible providers who had contact with this patient (ie: not director or influencer)
<b>No Utilization</b>	Patient is attributed to a provider, but has no eligible visits within this reporting period

\*\*Eligible providers are physicians or non-physician providers such as a nurse practitioner or physicians assistant.

Figure 23 below shows the risk adjusted difference in total cost of care. Overall, the total cost of care for patients when their PCPs are less engaged ranges from 12% (in Region 5) to 22% (in Region 6) above the risk adjusted, or expected, average. This analysis shows the importance of a strong primary care network that works with members to direct care and identify supports that can make a difference in both the quality of care and the total cost of care. It also demonstrates that these impacts are greater in some regions.

**Figure 23: Physician Influencer Analysis, CY 2012**



## CHIP Costs

Enrollment across all three components of Iowa’s CHIP program is also projected to increase over the next several years. In February of 2012, 63,172 children were enrolled in the CHIP program, which represented a 9% growth in enrollment from the same period the previous year.<sup>75</sup> The CHIP program as a whole is projected to cover a total of 64,995 children in SFY14 and 69,459 children in SFY15, which represent enrollment increases of 3% and 10%, respectively.<sup>76</sup>

Increased enrollment is one of the drivers of the double-digit increases to general fund expenditures for *hawk-i*. The total SFY14 budget for *hawk-i* reflects a 17.5% general fund increase from SFY13. The SFY15 budget reflects a 13.7% general fund increase over SFY14. The other primary budget driver is the declining FMAP. Iowa was the first state to receive contingency funding for FY 2011 to address the budget shortfall. HHS provided an additional \$28 million in Title XXI funding for the 2011 fiscal year.

## Medicare Costs

During SFY 2009, Iowa's spending on Medicare, which was \$7,987 per person, was much lower than the national average of \$9,477 per person.<sup>77</sup> These lower costs may, in part, be attributed to the low Medicare payment rates for both hospitals and independent providers. Iowa ranks 80th out of 89 Medicare payment localities for physicians (2007). These low payment rates do help keep Medicare costs and State expenditures low but members of the 2007 Task Force on the Iowa Physician Workforce concluded one down-side of these low rates is that providers are more reluctant to establish practices in the State, thereby contributing to the provider shortage.

## Commercial Insurance

After accounting for the 9.8% lower cost of living in Iowa (as measured by the Consumer Price Index), commercial health insurance premiums in Iowa are on par with the national average. When looking at 2011 premiums for employees with employer-based health insurance, the average single premium per enrolled employee in Iowa was \$4,742, compared to the U.S. average of \$5,222; the average employee-plus one premium per enrolled employee in Iowa was \$4,742, compared to the U.S. average of \$5,222; and the average family premium per enrolled employee in Iowa was \$13,030, compared to the U.S. average of \$15,022.<sup>78</sup>

The NovaRest Report for the Iowa Insurance Division shows the average increases in commercial insurance premiums between 2007 and 2011. Because Wellmark has such a large share of Iowa's insurance market, the unweighted data closely reflect Wellmark's rate increases even though increases at other companies differed from Wellmark's. To adjust for this, the authors provided both weighted and unweighted data. The weighted data was weighted by member months, which reflect the average rate increases across all members in Iowa, rather than rate increase by carrier.<sup>79</sup>

Across, all groups: individual comprehensive major medical, small group and large group, the unweighted data shows high increases in the average individual comprehensive major medical every year; somewhat smaller increases in small group rate, and even smaller increases in the large group rates.<sup>80</sup>

**Table 20: Unweighted Rate Increases**

Iowa State Average Rate Increases 2007-2011 - Unweighted					
Rate Group	2007	2008	2009	2010	2011
<b>Individual Comprehensive Major Medical</b>	11%	12%	14%	17%	11%
<b>Small Group</b>	9%	7%	12%	15%	10%
<b>Large Group</b>	5%	6%	8%	12%	5%

Source: NovaRest Report for the Iowa Insurance Division in Support of the Annual Report to the Iowa Governor and to the Iowa Legislature. November 2012.

When weighted, the pattern changes and the average small group rate increases at the highest rates.

**Table 21: Weighted Rate Increases**

Iowa State Average Rate Increases 2007-2011 - Weighted					
Rate Group	2007	2008	2009	2010	2011
Individual Comprehensive Major Medical	8%	9%	11%	19%	9%
Small Group	8%	10%	14%	16%	11%
Large Group	4%	5%	9%	14%	8%

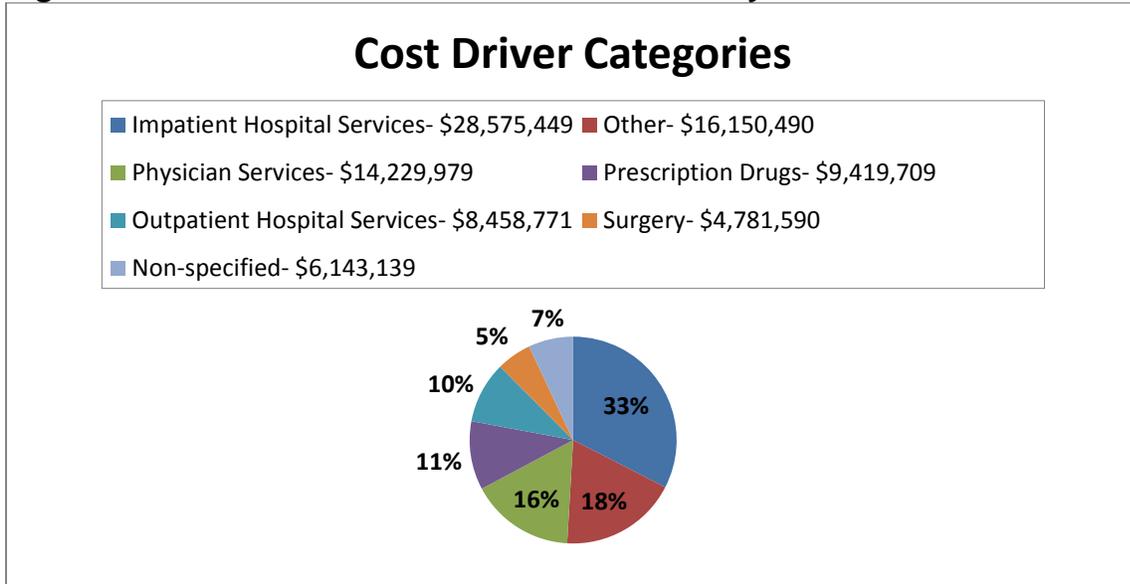
Source: NovaRest Report for the Iowa Insurance Division in Support of the Annual Report to the Iowa Governor and to the Iowa Legislature." November 2012.

As premiums in Iowa have steadily increased, workers' wages have not increased to an equal magnitude. From 2001 to 2011, health insurance rates increased an average of 12.6% every year; during that same time, weekly wages increased only 3.1% every year.<sup>81</sup>

**Insurance Carriers' Perceptions of Cost Drivers**

For this 2012 report, insurance carriers in Iowa identified what they believed to be the highest cost drivers. Ninety-three percent of cost increases are accounted for by six categories as identified below.

**Figure 24: Health Care Cost Driver as Identified by Iowa Insurance Carriers**



Source: Healthy Policy Corporation of Iowa. 2013. *Chartbook of the Quality and Financial Performance of the Health Industry in the Greater Iowa Area.*

## **5. Special Needs Populations and Factors Impacting Care, Health and Cost (Responds to Question 11)**

As in states across the country, Iowans have a variety of health care needs. Some individuals have special health care needs, and the transformed system must be aware of these and capable of serving these individuals in effective, efficient and appropriate ways. Populations are discussed below, including discussion of the number of individuals in Iowa; some of the factors that impact their care, their health, and the cost of their care; and the ways in which the transformed system will work to best serve these individuals.

### **Individuals Enrolled in Medicare and Medicaid – “Dual Eligible” Individuals**

One population that often has additional health care needs is that of individuals who are enrolled in both Medicare and Medicaid (“dual eligible” individuals). In 2011, Iowa had approximately dual eligible individuals, which is about 15% of Iowa’s Medicaid census. This 15% of the Medicaid census accounts for about 41% of Iowa’s Medicaid costs.

Due to the difficulty of finding comparative health status data for duals in Iowa and other states, the most recent information can be found from states researching their own dual eligible populations, in preparation for submitting proposals to CMS’ 2009 Request for Proposals to Integrate Care for Dual-Eligible Individuals. It should be noted that most state proposals focused on dual eligible populations with several eligibility exclusions and will be rolled out in select areas rather than statewide. However, with these caveats noted, it presents the most up-to-date information to enable us to extrapolate the health needs of the targeted demonstration group to dual eligible individuals statewide. Compared to other states who presently have signed memorandums of understanding (MOUs) to implement state demonstrations to integrate care for dual eligible individuals (and supplied adequate information on the utilization of their duals demonstration populations), Iowa’s dual eligible individuals receive LTCSS services to a greater extent than other states. Also, compared to other states, Iowan dual eligible individuals include significantly more individuals with serious mental illness in institutional or HCBS settings. However, Iowa follows a reverse pattern than other states in that a much higher percentage of individuals under age 65 receive LTCSS services compared to individuals 65 years and older. In most states, more individuals 65 years and older receive LTCSS services than individuals under age 65.

**Table 23: Care Setting for Projected Dual Eligible Demonstrations**

State	Total receiving LTCSS services	Total Individuals age 65+ receiving LTCSS services	Total Individuals under age 65 receiving LTCSS services	Total Individuals with serious mental illness in institutional or HCBS setting	Total Duals Population
<b>Illinois</b>	56,510	41,914	14,596	15,873	156,162
	36%	27%	9%	10%	NA
<b>Iowa</b>	27,866	8,300	19,566	15,404	62,714
	44%	13%	31%	25%	NA
<b>New York</b>	178,044	159,522	18,522	41,908	460,109
	39%	35%	4%	9%	NA
<b>Virginia</b>	19,316	15,648	3,668	5,825	65,415
	30%	24%	6%	9%	NA
<b>Washington</b>	56,334	43,586	12,748	2,653	134,421
	42%	32%	9%	2%	NA

Source: Review of State proposals submitted in response to CMS' 2009 Request for Proposals to Integrate Care for Dual Eligible Individuals.

Compared to national averages and current states with signed dual demonstration (MOUs), Iowa's duals spend a larger percentage of Medicaid dollars towards Medicare premiums and long-term care services, a smaller percentage towards Medicare-covered acute services, and similar levels towards acute services not covered by Medicare and prescribed drugs.

**Table 24: Distribution of Medicaid Spending for Dual Eligibles by Service**

Location	Medicare Premiums	Medicare-Covered Acute	Acute Not Medicare	Prescribed Drugs	Long-Term Care	Total
<b>United States</b>	9%	18%	5%	1%	67%	100%
<b>California</b>	12%	24%	3%	1%	59%	100%
<b>Illinois</b>	8%	19%	6%	1%	66%	100%
<b>Iowa</b>	13%	9%	6%	1%	71%	100%
<b>Massachusetts</b>	6%	18%	20%	1%	56%	100%
<b>Minnesota</b>	5%	27%	3%	1%	65%	100%
<b>New York</b>	5%	14%	5%	1%	75%	100%
<b>Ohio</b>	6%	11%	4%	1%	79%	100%
<b>South Carolina</b>	9%	30%	2%	1%	58%	100%
<b>Virginia</b>	9%	12%	3%	1%	76%	100%
<b>Washington</b>	11%	7%	5%	1%	75%	100%

Source: Kaiser Family Foundation, State Health Facts. Duals Spending by Service.

In some cases, these higher costs could be prevented by ensuring that dual eligible individuals receive appropriate care in the most appropriate setting, including ensuring that preventive care is accessible and utilized to prevent worsening of conditions and hospitalizations. To assess whether this is the case, researchers used Preventive Quality Indicators (PQIs), developed by the Agency for Healthcare Research and Quality (AHRQ), to examine quality of healthcare and outcomes for dual eligible clients. PQIs measure ambulatory care sensitive conditions that result in hospital admissions and provide insight into rates at which outpatient care could have prevented a hospitalization. Results of this study indicated that in 9 of 13 PQI measures, Iowa's dual eligible population exceeded national benchmarks for rates of conditions that resulted in preventable hospitalizations (Medicaid Value Management (MVM) 2011).<sup>82</sup>

This study also revealed high cost areas including diabetes, congestive heart failure and chronic obstructive pulmonary disease. Additionally, Iowa's dual eligible individuals had higher than average rates of dehydration, bacterial pneumonia and urinary tract infection (all of which are preventable) that resulted in hospitalization. Further, analyses of claims data indicate that rates of hospital readmissions are higher for dual eligible individuals (9.6%) than for individuals who are enrolled in Medicaid but not Medicare (7.2%), and that costs associated with those readmissions are higher for dual eligible individuals (average of \$8,894) and Medicaid-only individuals (\$6,363).

What these results suggest is that, while many of the healthcare costs related to care for dual eligible individuals are not preventable, some costs are. By recognizing and treating symptoms in a timely fashion, dual eligible individuals will be healthier, and costs for preventable health concerns will be reduced.

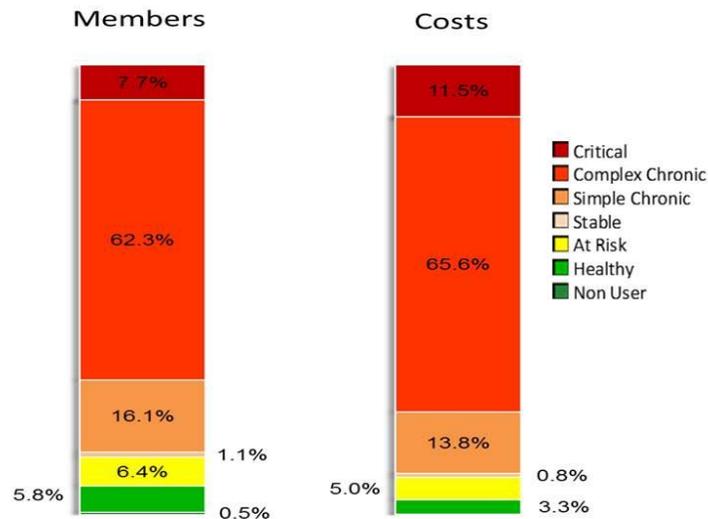
Iowa's transformed healthcare system will need to be able to provide support and care for dual eligible individuals that is sensitive and responsive to their needs, provide appropriate care coordination, and work to ensure that needed services are accessed at the appropriate times. The system will need to work with dual eligible individuals and their families and support systems to help prevent conditions from worsening and to help individuals manage chronic conditions. While dual eligible individuals will be served by the ACOs from the beginning of implementation of the ACO model (Phase 2), initially the ACOs will not be held accountable for integration of LTCSS and behavioral health services. In the early phases the ACOs will be responsible for building their capacity to effectively coordinate care and support dual eligible individuals, working with waiver services and providers, and building relationships with community organizations that provide support to dual eligible individuals. Before ACOs begin to be held accountable for integrating LTCSS and BH services, ACOs will undergo comprehensive assessments to determine their capacity and readiness for serving this population. The ACOs will be expected to coordinate with existing medical health homes, the BIPP initiative, Integrated Health Homes, and other initiatives in Iowa that currently serve dual eligible individuals.

## Individuals with High Long Term Care Needs

In addition to dual eligible clients, many other lowans have high long term care needs. These include individuals who receive care in any of Iowa's 443 nursing facilities<sup>83</sup>, and those enrolled in a HCBS waiver or on a waitlist for one of the HCBS waivers.

**Figure 25: Population and Cost Distribution for LTCSS**

Population distribution and cost distribution for members receiving Institutional Long Term Care and Waiver Services



Based on CY 2012 Iowa Medicaid excluding Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network & Iowa Care

As with dual eligible clients, many of these individuals have higher needs for services and higher costs associated with those services. The same opportunities identified above are relevant for this population, including improving health outcomes and reducing costs by providing more timely access to care, improving transitions and follow-up care upon hospital discharge, and improving utilization of prevention services.

It will be critical for the ACOs to develop and strengthen relationships with all providers of LTCSS in Iowa, to help ensure that services are coordinated across systems. As has been discussed throughout this SHIP, in Phase 3 of the SIM initiative, the State intends to hold ACOs accountable for coordinating services across systems of care, including LTCSS, behavioral health, and physical health services. In the first two phases of the SIM implementation, ACOs will focus on developing and strengthening relationships with providers. The ACO model will build upon and leverage strengths in the existing system of care, and work to ensure that services are effectively and efficiently utilized.

## Individuals with Severe and Persistent Mental Illness or Severe Emotional Disturbance

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 4.9 % of Iowa's population aged 18 and older has severe and persistent mental illness (SPMI).<sup>84</sup> The Governor's Healthy Iowans 2010 report, states that the incidence of Serious Emotional Disturbances (SED) among children is 10-12%, a rate that is very similar to the national rate.<sup>85</sup> When defined more broadly, 19% of children in Iowa between the ages of 2 and 17 had a parent who reported that a doctor has told them their child has autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral/conduct problems. This rate is from 2010-2011; in 2007 the reported rate was 17%.<sup>86</sup>

In Iowa, as in many states, behavioral health services are often provided in a silo and are not well coordinated or integrated with physical health services. A primary driver of the system transformation envisioned in this SHIP is this integration. A primary requirement of ACOs in Phase 3 of this SIM work is to integrate and coordinate behavioral health services with physical health services and LTCSS for people who need these services, ensure access to services, and increase access to preventive services and early detection. ACOs will be held accountable for this integration and coordination, and for working with and leveraging strengths in the existing system. Measures to which ACOs will be held accountable are discussed in Section 10 of this SHIP.

In addition to ACO accountability, the State has made a tremendous investment in the Integrated Health Home program. Implementing this has been a collaborative effort across DHS as well as with providers and with the statewide managed behavioral health vendor, Magellen. As a result there is a well-developed infrastructure in place that is supporting individuals needing behavioral health services. This foundation will be instrumental in integrating all services into ACOs and in ensuring the ACOs have the expertise to provide necessary services to individuals needing behavioral health services.

## Special Populations of Children

In Iowa, approximately 28,000 children (about 3.9%) under age 18 are estimated to have a disability.<sup>87</sup> These children often need more services generally, and can have a need for more intensive care coordination services, particularly across systems such as primary care, LTCSS, and/or behavioral health services. According to the Governor's Healthy Iowans 2010 report, the incidence of Serious Emotional Disturbances among children is 10-12%, a rate that is very similar to the national rate.<sup>88</sup> When defined more broadly, 19% of children in Iowa between the ages of 2 and 17 had a parent who reported that a doctor has told them their child has autism, developmental delays, depression or anxiety, ADD/ADHD, or behavioral/conduct problems.

Most children on Medicaid do not have major presenting health conditions at the current time, but they do face social and economic concerns (social determinants of health) which are much more likely to negatively impact their health trajectory than other children. While the medical community alone cannot address such needs, the community can identify and take action, often through referrals to other education, human service, and community services which can positively impact their healthy development. In particular, many health conditions can be traced back to young children who experience early childhood adversity and toxic stress through their environment. Identifying and responding to this special population of children, however, requires a different approach than solely providing medical care.

Another group of children who may have higher or different health care needs are children in foster care. As of March 2013, the Children's Defense Fund estimated that there were 6,344 children in foster care in Iowa.<sup>89</sup> Multiple studies over the past twenty years document that the health care needs of children in foster care are greater than those who are not in foster care. They have higher rates of physical disabilities, and intellectual or developmental disabilities, and mental health issues than children who are not in out-of-home-care.<sup>90</sup> In addition to having higher health care needs than other children, these children often need more coordination of care, particularly if they move in and out of foster care and reunification with their family.

## **Individuals who are Experiencing Homelessness**

The Iowa Institute for Community Alliances estimated that in Iowa in 2012, over 16,000 Iowans were experiencing homelessness<sup>91</sup>. Individuals who are experiencing homelessness typically face greater threats to their health and have higher rates of chronic conditions and mental health and substance abuse issues. In addition, people experiencing homelessness face a number of barriers to accessing healthcare services, including lack of insurance coverage, lack of transportation to providers, long wait times to see providers, and competing priorities such as food and shelter needs. These barriers contribute to lower rates of accessing preventive care and other care in a timely fashion, which contribute to more problematic and complex health conditions<sup>92</sup> and, as a result, higher costs.

As more people who are experiencing homelessness gain Medicaid coverage in Iowa (due to the Iowa Health and Wellness Plan), it will be critical for ACOs, as part of this SIM work, to conduct enhanced outreach to the people they serve who are experiencing homelessness to engage these individuals in care. ACOs will be held accountable for ensuring that these individuals access care and that their care is coordinated across systems.

## **Incarcerated Populations**

According to Iowa's Department of Corrections, in November 2013, there were 8,227 people incarcerated<sup>93</sup> with another 30,500 individuals in community corrections. The IME has already begun to do more outreach to enrolled eligible individuals in Medicaid,

especially with the implementation of the Iowa Health and Wellness Plan in January 2014. As part of the SIM work, the IME is forming work groups with Department of Corrections to identify ways to bring community-based corrections groups into the process to help proactively educate and enroll incarcerated individuals, and those on parole or probation.

## **Native American Population**

Iowa is home to about 2,219 American Indians/Alaskan Natives, with about 1,000 of those residing on the Sac and Fox/Meskwaki Settlement.<sup>94</sup> While this is a relatively small percentage of Iowa's overall population, American Indian/Alaska Natives (AI/AN) often face additional barriers to accessing health care, including cultural and geographic barriers, and additional economic factors. American Indian/Alaska Natives have an infant death rate that is 60% higher than the rate for Caucasians. This population is twice as likely to be diagnosed with diabetes; and experiences higher rates of obesity, heart disease, cancer, stroke, and behavioral health needs including completed suicides.

As part of the SIM work, attention will be paid to ensuring that the system is patient-centered. In part, this means ensuring that services are culturally appropriate and available in settings that are accessible to the individuals being served. ACOs will need to pay special attention in their outreach efforts to the AI/AN they serve, and to ensuring that these individuals have access to the services they need, especially preventive services and behavioral health services.

## **6. Opportunities and Challenges to Adoption for Health Information Exchange (HIE) and Meaningful Use of Electronic Health Record Technologies (Responds to Question 5)**

Iowa's reform goals and strategies recognize that accountable care systems require robust information system capacity. Individual providers, health care organizations, and the state must each have the capacity to collect, analyze and share information for various purposes related to their respective roles fostering the implementation of accountable care. For providers, information systems must support care planning and coordination of care, including use of a comprehensive patient record and standard set of data, patient registries, care planning alerts, and other population health tools to plan and monitor patients care. Data analytics must help both providers and ACOs to understand the mix of patient acuity, service quality and costs, and performance against benchmark VIS metrics. The state needs the capacity to consistently collect and analyze standardized data in order to successfully implement value-based payment reforms involving Iowa public and private payers, ACOs, and providers.

Iowa's SHIP calls for building on the well-established, multi-faceted Iowa e-Health initiative that began in 2008 and is currently promoting statewide Health Information

Technology (HIT) adoption and Health Information Exchange (HIE) development. Iowa's e-Health infrastructure and accomplishments to date reflect active engagement across sectors, involvement of the IME, and sustained leadership and administrative support by the IDPH for development of the Iowa Health Information Network (IHIN). Like other states, Iowa faces challenges to address current barriers to the adoption of HIT and HIE to support accountable care delivery and payment systems.

## **As Is – Iowa's Current Health Information Landscape**

### **The Iowa e-Health Initiative**

In 2008, the Iowa Legislature enacted House File 2539, which established eleven advisory councils charged with making recommendations for health reform in Iowa. One of the advisory councils is the e-Health Executive Committee and Advisory Council, administered by the IDPH. The voting members of the Executive Committee include diverse representation, perspectives and expertise reflecting key stakeholders and the Iowa health care marketplace. These include chief information officers from the state's three largest private health care systems as well as the University of Iowa Hospitals and Clinics; a representative from a rural hospital selected by Iowa Hospital Association; a consumer member of the State Board of Health; a licensed practicing physician selected by the Iowa Medical Society; a licensed and practicing nurse selected by the Iowa Nurses Association; and an insurance carrier selected by the Federation of Iowa Insurers.

The adjunct 19 member non-voting Advisory Council includes: a pharmacist; a licensed practicing physician; a consumer member of the State Board of Health; a member from the Iowa Medicare Quality Improvement Organization; the executive director of the Iowa Communications Network; a representative of the private telecommunications industry; a representative of the Iowa collaborative safety net provider network; a nurse informaticist; and eleven additional members representing key stakeholder groups, including the IME.

The IME is an active participant in all e-Health workgroups, and meets monthly with the IDPH to coordinate efforts regarding HIE, HIT, and the adoption of electronic health records. IME is also actively involved with Iowa's health information exchange, the IHIN, to provide requirements to advance IME priorities such as quality measure reporting.

### **Statewide Goals, Planning and Resources for HIT and HIE**

In its enabling legislation, the Iowa e-Health Executive Committee, with technical assistance from the e-Health Advisory Council and IDPH, was charged with the following:

1. Developing a statewide health information technology plan by July 1, 2009;
2. Identifying existing and potential health IT efforts, and integrating with state and national efforts to avoid incompatibility and duplication;

3. Coordinating public and private efforts to provide the network and communications backbone for health IT;
4. Promoting the use of telemedicine defined as the use of communications and information technology for the delivery of care, usually in ways not otherwise available in the patient's immediate environment;
5. Addressing workforce needs generated by increased use of health IT;
6. Recommending rules to be adopted in accordance with Iowa Code chapter 17A to implement all aspects of the plan and the network;
7. Coordinating, monitoring and evaluating the adoption, use, interoperability, and efficiencies of health IT in the state;
8. Seeking and applying for any federal or private funding to assist in implementation and support of the health IT system; and
9. Identifying state laws and rules that present barriers to development of the health IT system.

The e-Health Executive Committee and Advisory Council began meeting in January 2009, and continues to meet bi-monthly to engage in critical planning discussions, establish priorities, and execute project activities. Workgroups meet more frequently to further define, research, and carry out project activities.

Following implementation of HITECH as part of the ARRA, in 2010, the IME conducted provider surveys in collaboration with Iowa e-Health to understand the barriers and utilization of EHR in Iowa across a wide range of provider types, including home health care, long term care, laboratories, and pharmacies.

### **Strategic and Operational Plan for HIT Adoption and HIE**

Building upon the survey results, the 2010 Iowa e-Health Strategic and Operational Plan<sup>95</sup> was created as a required deliverable of ONC's HIE Cooperative Agreement Program. It provided Iowa access to \$8,375,000 of planning and implementation funds from 2010 to 2014. Telligen, (formerly known as The Iowa Foundation for Medical Care (IFMC)) took on the role as Health Information Technology Regional Extension Center (HIT REC)<sup>96</sup> for Iowa under a HITECH ONC grant. As part of the eHealth Advisory Council, the IME developed a close collaboration with the HITREC and eHealth Initiative partners to develop support for common goals for EHR adoption, addressing issues highlighted by survey results. In 2012, the Strategic and Operational Plan was updated to reflect the evolution of Iowa's HIT efforts and goals for HIE development moving forward. This most recent plan was developed through a transparent, multi-stakeholder process to identify and satisfy the business and clinical requirements for a statewide HIE. The Plan includes 10 goals reflecting broad priorities for establishing sustainable organizational, technical and financial health information infrastructure across Iowa, making digital information available to improve health care as part of Iowa's health reform goals.

As another collaborative planning effort, the IME developed and submitted its State Medicaid HIT Plan (SMHP) to CMS, outlining plans for establishing the Iowa EHR

Incentive Program. Through its IAPD approved in early, 2012, Iowa Medicaid secured another \$2,295,000 through FFY 2013 to support HIT adoption and HIE implementation activities.

## Leveraging Iowa’s Information System Capacity

Iowa’s strategy and plans to develop statewide interoperability began with an understanding of current HIT and HIE capacity across Iowa’s various types of providers and major health systems, based on a 2010 environmental scan.

**Table 25: HIT/HIE Capacity (2010)**

Environmental Scan – HIT/HIE Capacity (as of 2010)	
<b>Hospitals</b>	<p><b>Electronic capabilities within hospital/health system:</b></p> <ul style="list-style-type: none"> <li>• 32% (38) hospitals are able to exchange <i>lab reports</i> with other hospitals in their system, 71% (25) of those had 2-way communication.</li> <li>• 28% (33) hospitals are able to share <i>patient discharge summaries</i> with other hospitals in their system.</li> <li>• 21% (25) hospitals are able to exchange <i>clinical care summaries</i> with other hospitals in their system, 8% (2) of those had 2-way capabilities.</li> </ul> <p><b>Electronic capabilities with providers outside the hospital/health system:</b></p> <ul style="list-style-type: none"> <li>• 11% (13) hospitals are able to exchange <i>lab reports</i> with hospitals outside their system, 15% (2) of those had 2-way communication.</li> <li>• 5% (6) hospitals are able to share <i>patient discharge summaries</i> with hospitals outside their system.</li> <li>• 9% (10) hospitals are able to share <i>patient discharge summaries</i> with clinics outside their system.</li> </ul>
<b>Provider Practices and Clinics</b>	<p><b>Approximately 46% (145) provider practices have an EHR.</b></p> <ul style="list-style-type: none"> <li>• 82% (123) providers with an EHR access patient allergy and medication lists most or all of the time.</li> <li>• 78% (117) of providers with an EHR access a clinical care summary (patient problem or procedure lists) most or all of the time.</li> <li>• 77% (113) of providers with an EHR access clinical notes most or all of the time.</li> <li>• 60% (87) of providers with an EHR access e-prescribing most or all of the time.</li> <li>• 40% (123) of providers use e-prescribing software separate from an EHR.</li> <li>• 59% (77) of providers with an EHR view image results most or all of the time.</li> <li>• 57% (80) of providers with an EHR receive structured lab results most or all of the time.</li> <li>• 23% (28) of providers with an EHR access reminders for guideline-based interventions and/or screening tests most or all of the time.</li> <li>• 13% (11) of <i>providers</i> with an EHR access public health reporting most or all of the time.</li> <li>• Iowa will collect data about patient portal functionality as part of future environmental scan efforts.</li> </ul>

Environmental Scan – HIT/HIE Capacity (as of 2010)	
<b>Payers</b>	<ul style="list-style-type: none"> <li>100% of payers accept electronic eligibility and claims transactions, in accordance with HIPAA regulations.</li> </ul>
<b>Pharmacy</b>	<ul style="list-style-type: none"> <li>63% (569) of Iowa's 913 licensed pharmacies can accept electronic prescribing and refill requests.</li> <li>8% (1080) of Iowa providers are certified to use Surescripts.</li> <li>16% (2,813,116) prescriptions were routed electronically in 2009.</li> </ul>
<b>Labs</b>	<ul style="list-style-type: none"> <li>50% of labs are able to produce and deliver structured lab results (using a laboratory information system software product).</li> <li>39% of labs are able to receive orders electronically (using an electronic order interface with the main reference lab).</li> <li>40% of lab results are currently being delivered electronically (to at least some of their providers).</li> </ul>
<b>Health Departments</b>	<ul style="list-style-type: none"> <li>IDPH currently receives electronic immunization and notifiable laboratory results, primarily through web-based data entry systems [i.e., Immunization Registry (IRIS) and Iowa Disease Surveillance System (IDSS)].</li> <li>More than 1,000 organizations are using IRIS; 2,613,670 vaccinations were added to IRIS in 2009.</li> <li>Approximately 210 organizations are using IDSS; 53,000 reports of infectious diseases were submitted to IDSS in 2009. IDPH currently receives HL7 messages into IDSS from the State Hygienic Laboratory.</li> <li>Development of a plan for IDPH to collect syndromic surveillance data are contingent upon the statewide HIE being able to provide the necessary infrastructure.</li> </ul>

**Table 26: Prevalent EHR Products in Iowa**

<b>Hospitals Med-Surg Areas</b>	<ul style="list-style-type: none"> <li><i>Healthland</i>: 13 Hospitals (11% of total facilities representing 900 acute-care beds)</li> </ul>
	<ul style="list-style-type: none"> <li><i>Cerner</i>: 11 Hospitals (9% of total facilities representing 737 acute-care beds)</li> </ul>
	<ul style="list-style-type: none"> <li><i>Meditech</i>: 11 Hospitals (9% of total facilities representing 737 acute-care beds).</li> </ul>
	<ul style="list-style-type: none"> <li><i>Epic</i>: 5 hospitals (4% of total facilities representing 741 acute-care beds). 10 senior affiliate Iowa hospitals in Iowa Health System d/b/a UnityPoint Health (6% of total facilities representing 1368 acute-care beds) Note: this reflects updated information and is current as of submission of the SHIP.</li> </ul>
	<ul style="list-style-type: none"> <li><i>Other</i>: EHRs with a presence in Iowa include: Allscripts, eClinicalWorks, Greenway, HMS, Medhost, Siemens, Keane, and McKesson.</li> </ul>

**Table 27: Market Reach of Ambulatory EHR Products**

Provider Practices and Clinics	Ambulatory EHR Product	Estimated Market Reach
	Allscripts	28% (33)
	McKesson	11% (13)
	Sage	9% (11)
	Healthland	8% (9)
	Cerner	(8)
	LSS	6% (7)
	Next Gen	5% (6)
	Other	(26%)

Iowa's health care landscape includes several health systems, each of which has taken steps to implement electronic health information systems and HIE capacity.

**Table 28: Health Systems and HIT-HIE Capacity**

Health Systems and HIT-HIE Capacity	
<b>University of Iowa Hospital and Clinics (UIHC)</b>	UIHC uses a CCHIT certified EHR with full computerized physician order entry in place across the inpatient and outpatient environments. The EHR is used by more than 760 staff physicians, 720 physicians in training, 1850 nurses and 4600 other professional and support staff. UIHC is currently HIMSS Stage 6 certified in its deployment of its EHR system and supports extensive device integration between bed-side physiologic monitoring devices and the EHR, as well as bar-code scanning of inpatient and outpatient medication administrations.
<b>Mercy Health Network (MHN)</b>	A joint venture between Catholic Health Initiatives and Trinity Health – Novi. Includes 5 major medical centers (Clinton, Des Moines, Dubuque, North Iowa, and Sioux City), 4 rural community hospitals, 24 affiliated hospitals, and 98 physician clinic sites. The network includes other facilities such as nursing homes and inpatient hospices. Some sites use common clinical EHRs. Some have computerized physician order entry (CPOE), electronic nursing documentation, and physician portals. Sites without health IT technologies are working to implement.
<b>Mercy Health Network – North Iowa</b>	More than seven North Iowa hospitals and the rural referral hospital have an integrated comprehensive EHR system, the first of its kind in a U.S. rural health care setting. The system provides remote access to physicians, pharmacists and allied health professionals; shared clinical decision support logical rules; shared care (order) sets for CPOE; barcode medication administration scanning; and Nova Medicity access to lab results.
<b>Genesis Health System</b>	Genesis utilizes a completely paperless inpatient EHR. A majority of clinical information is captured electronically at the bedside. Automation has occurred in the following care areas: Emergency Department, Laboratory, Pharmacy, Radiology, Order Management, Surgery, Intensive Care, OB/Nursery, Nursing, and Home Health. Genesis is currently implementing a physician office EHR.
<b>Iowa Health System d/b/a UnityPoint Health (UPH)</b>	Electronic medical records are in use across the inpatient and outpatient environment including homecare. All ten UPH hospital senior affiliates in Iowa, utilize an EHR. Clinics support more than 280 clinic locations with nearly 900 physicians and providers in rural and urban settings; most ambulatory clinics are utilizing a CCHIT certified HER. This information is current as of SHIP submission.
<b>Broadlawns Medical Center</b>	Ranks among a select group of hospitals across the country that are HIMSS Stage 6 certified for successful adoption of EHR capabilities. Stage 6 certification requires implementation of physician documentation and charting for at least one patient care service area. Broadlawns has achieved this documentation in all inpatient care areas.
<b>IowaCare: Referral Request and Record Exchange</b>	A limited information exchange pilot project is between two HIMSS Stage 6 hospitals [i.e., UIHC and Broadlawns Medical Center]. IME prompted these two large Medicaid providers, which use different EHR products, to move forward with testing data exchange concepts. UIHC has been able to use Epic software to enable secure communication with selected providers at Broadlawns Medical Center (which uses MEDITECH software). In early 2011, the exchange between these two organizations was limited to securely exchanging PDF documents.

## Federally Qualified Health Centers

In 2009, Iowa's health center controlled network, INConcert Care, Inc., received a 3-year EMR implementation grant from the Health Resource and Services Administration (HRSA) totaling over \$1.3 million. Along with a variety of other funding sources, the grant helped fund implementation of GE Centricity EMR in six Federally Qualified Health Centers (FQHCs) in Iowa and one in Nebraska. NextGen and EHS EHR systems were subsequently selected for implementation within other individual FQHC locations.

INConcert Care also provides other services including dental clinical information systems to eight FQHCs and population health management software (registry) to 15 FQHCs. All software applications, including e-mail, are served up out of a data center located in Davenport, IA. INConcert Care has executed a teaming agreement with the Regional Extension Center and participates in the Iowa Health Systems d/b/a UnityPoint Health HealthNet connect) FCC connectivity project. This connectivity provides for up to 160 mg connectivity for the exchange of clinical data from FQHC EMR systems through the Statewide Health Information Exchange. In addition, INConcert Care, Inc purchased GE's patient portal software to allow the FQHC's to participate in the secure messaging function of the State e-health network. The levels of HIT and HIE adoption in FQHCs is enabling a number of FQHCs to participate as part of the state's Health Home program.

## Veterans Administration

Within Iowa, the Veterans Health Administration (VHA) has medical centers in Des Moines and Iowa City and eleven community based outpatient clinics. Every location is connected within the VA's infrastructure using VistA and Computerized Patient Record System (CPRS) to share clinical information both within state VA locations, and worldwide within the VA's infrastructure. As part of the nationwide VA HIT and HIE strategies, Direct secure messaging for HIE outside of the VA and the Blue Button initiative (a federal initiative that enables individuals to download their health information) were piloted in Iowa VA medical centers in 2013. Veterans can use the Blue Button on the MyHealthVet website to download demographic information (age, gender, ethnicity and more); emergency contacts; a list of their prescription medications, clinical notes; and wellness reminders.

## Indian Health Services

Tribes in Iowa served by the Indian Health Services system are taking steps to implement Resource and Patient Management System (RPMS) offered through the Indian Health Services and connect with HIE. The Winnebago and Pongo tribes utilize Resource and Patient Management System (RPMS) provided by Indian Health Services, a product that is certified for supporting meaningful use. The Ponca Tribe also implemented the IHS RPMS EHR about a year ago. The Ponca tribe is planning to enhance their electronic data exchange capabilities, particularly with outside labs. The Meskwaki Settlement has plans to utilize the RPMS in the future.

## Fostering Meaningful Use – Iowa’s EHR Incentive Program

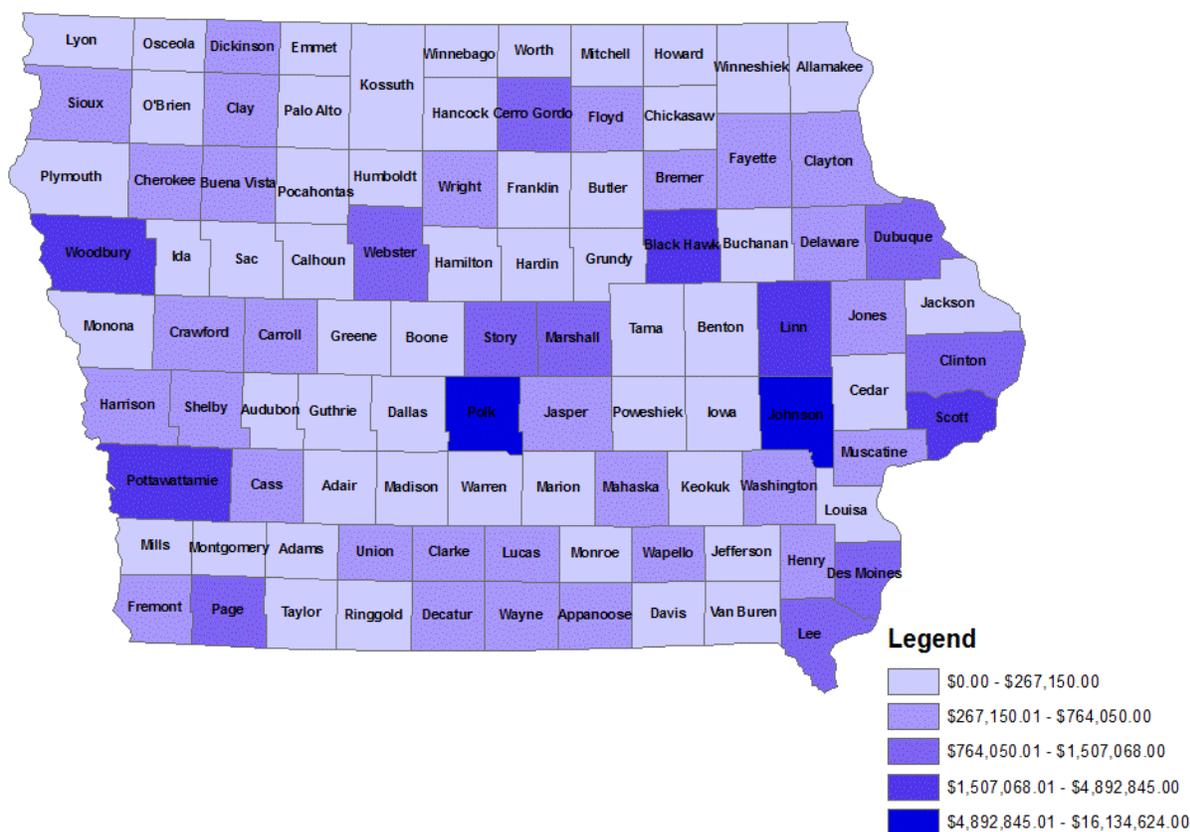
Iowa was one of the first states to launch its EHR Incentive program, developing capacity to release Medicaid incentive payments in January 2011. Based on estimates of the numbers of eligible providers and hospitals, Iowa’s REC was charged with assisting 1,200 primary care providers and 84 critical access/rural hospitals with improving patient care through the adoption and meaningful use of electronic health records. Technical assistance was targeted to primary care practices with ten or fewer professionals with prescriptive privileges as well as public and critical access hospitals (CAHs) providing primary care, and community and rural health centers that predominantly serve the uninsured, underinsured and underserved.

IME believed that nearly all Acute Care and Critical Access Hospitals would meet the 10% Medicaid patient/encounter thresholds. More difficult to predict was the number of Eligible Professionals who would meet 30% Medicaid patient/encounter thresholds (20% for pediatricians). As providers began to register and attest, variances emerged (such as the number of estimated versus actual nurses and midwives) based on providers who enrolled in the EHR Program at the facility level versus individually. Physician Assistants (PA) were not coded individually as a Medicaid provider type in the state’s MMIS making it difficult to predict the number that would be eligible for incentives.

The map below depicts payments made to providers across the State of Iowa as of July 12, 2013. The uneven levels of EHR Incentive Program attestation and payment, along with the low payments especially in rural counties, highlight where efforts to foster adoption are most challenging.

**Figure 26:**

Medicaid EHR Incentive Payments by County as of 7/12/2013



### Hospital Participation

Iowa’s REC and Hospital Association worked extensively with Iowa hospitals to assist with the attestation process. As of July 1, 2013, 92 out of the state’s 118 hospitals attested to adopting an EHR and 49 hospitals attested as meaningful users. All the hospitals that attested are critical access hospitals.

### Provider Participation

Through the Iowa EHR Incentive Program, and with assistance from the Iowa Regional Extension Center, provider adoption among eligible providers has steadily increased, although significant efforts remain to achieve widespread EHR implementation and use. Approximately 30% of Iowa’s provider population adopted and attested to having an EHR as of July 1, 2013.

The IME's provider portal was enhanced to survey providers regarding their EHR implementation and meaningful use status and future plans as part of provider re-enrollment, allowing Iowa to continue to monitor EHR adoption progress within the state, beyond those providers who are receiving incentives. Provider re-enrollment launched in May 2013. As of August 28, 2013, 11,987 providers responded to questions about EHRs and health information exchange as part of the re-enrollment process through the IME's provider portal.

- When asked if the provider currently used an EHR system, 76% responded that they did compared to the 24% who did not.
- For those who responded that they didn't use an EHR, just under half had plans to purchase an EHR in the next five years.

Providers who responded affirmatively that they used an EHR were asked if the EHR was certified for meaningful use<sup>97</sup>, about current or planned connection to the health information exchange (Iowa Health Information Network), barriers to EHR use, and what Medicaid could do to assist providers.

- A majority of Iowa providers are using certified EHR technology (CEHRT).
- A small percentage of providers not directly affiliated with hospitals and using their systems are currently connected to IHIN to exchange information (19%); some reported plans to connect in the next year (25%) or 2-3 years (14%).
- Under half (46%) of providers who responded noted that they had no plans to exchange information.

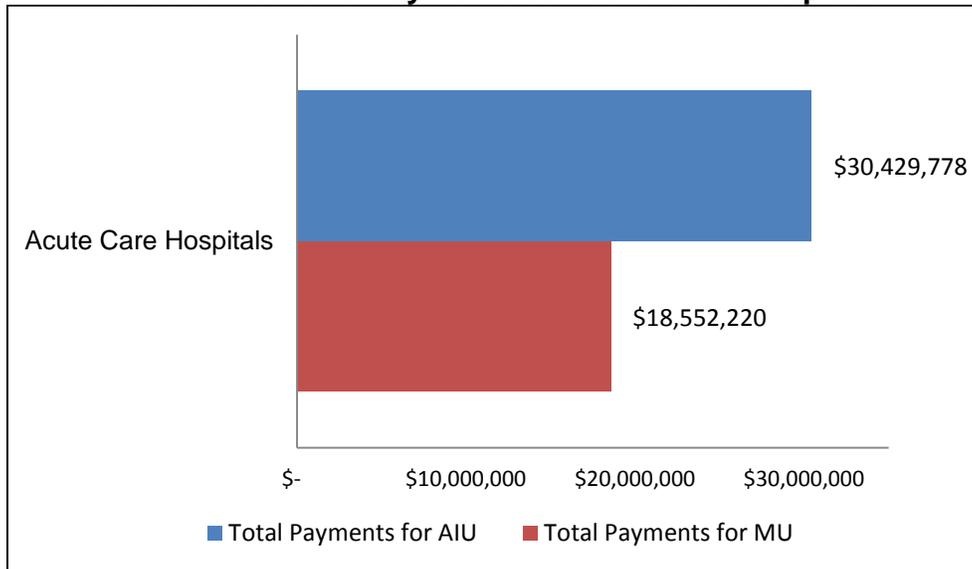
Iowa providers, like those common in other states, report that barriers to adoption include costs, lack of technical support, confusion and decreased productivity during the transition to use of the EHR during processes of care.

### **Moving from AIU to Meaningful Use**

As in other states, Iowa is experiencing differences between the numbers of eligible providers and hospitals making an initial attestation (AIU) and returning to attest to meaningful use (MU). As of July 2, 2013, the IME paid out \$78,509,607.00 in incentive payments to 1215 EPs and 92 EHs for AIU. Limited numbers of providers (489) and hospitals (47) also attested to meaningful use, and over 200 EPs registered for Medicaid incentives at the CMS Registration and Attestation site have yet to attest.

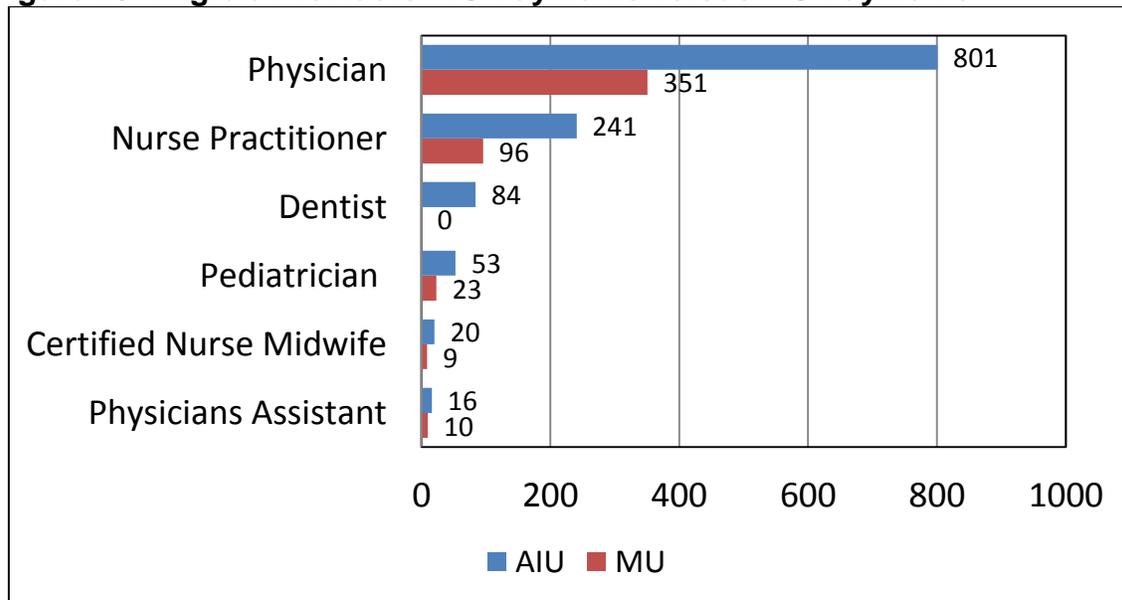
Currently, 47 hospitals, or 51%, have attested to meaningful use. This level falls behind IME's target of 70 hospitals attest to second year payments. A priority for IME is to continue to reach out to hospitals to encourage attesting to meaningful use to meet or exceed our goal of 70 hospitals receiving a second year payment.

**Figure 27: Medicaid Incentive Payments to Acute Care Hospitals**



As the figure below represents, roughly 40% of providers moved on from the adoption and implementation stage to meaningful use of their EHR as of July 2013.

**Figure 28: Eligible Providers AIU Payments versus MU Payments**



### EHR Incentive Program Administration

The EHR incentive payment process was successfully integrated within the existing business processes of the IME. The IME’s provider portal was enhanced to survey providers regarding their EHR implementation and meaningful use status and future plans. This survey is collected as part of provider re-enrollment and allows Iowa to

continue to monitor EHR adoption progress within the state, beyond those providers who are receiving incentives. Provider re-enrollment launched in May, 2012.

On April 2, 2012, IME launched its new software, the Provider Incentive Payment Program (PIPP) for attestation submission and review. This software interfaces with the MMIS claims payment system to disburse the payments to providers.

The IME continues to work with the providers and the Regional Extension Center to identify qualified providers and encourage them to attest. The IME still anticipates that during 2012-2016, an additional 10% of the remaining eligible providers will request EHR incentive payment each year.

## Health Information Exchange

### The Iowa Health Information Network (IHIN)

A key element of Iowa's Strategic and Operational plan that was submitted and approved by the ONC called for establishment of the Iowa Health Information Network (IHIN), to be administered by the Iowa Department of Public Health (IDPH).

On April 12, 2012, Governor Branstad signed into law e-Health bill SF 2318, establishing the policy framework necessary to move forward with IHIN development and operations. The bill included:

- Liability protections for providers related to the use of information obtained through the Iowa Health Information Network (IHIN).
- Financing provisions, including fee collection for participation in the IHIN, a separate fund for revenue and expense activities, authority for the Iowa Department of Public Health to use this nonrevertible funding for the specific requirements of the IHIN and the Iowa e-Health collaborative work of the Health Information Exchange grant.
- Provisions for development and oversight of the IDPH's annual eHealth budget and financial model for IHIN by the e-Health Advisory Council and the State Board of Health.
- Policy framework for patients to "opt-out" of having their health information exchanged through IHIN.

### Statewide HIE Goals and Strategies

A blueprint for building IHIN was described as part of Iowa's revised 2012 Strategic and Operational Plan (SOP) (<http://www.iowaehealth.org/documents/plans/64.pdf>) and its ten goals and associated objectives.

**Figure 29: Overview of Iowa SOP Goals and Objectives**

<p>The following outline provides an overview of the goals and objectives:</p> <p><b>Goal 1: Build awareness and trust of health IT</b> Objective 1.1: Establish a program brand and identity. Objective 1.2: Begin raising awareness about health IT and Iowa e-Health. Objective 1.3: Engage consumers to obtain their perspectives, concerns and priorities. Objective 1.4: Develop and execute a statewide communication and outreach campaign.</p> <p><b>Goal 2: Promote statewide deployment and use of electronic health records</b> Objective 2.1: Provide technical assistance to providers adopting and implementing EHR systems and connecting to the statewide HIE. Objective 2.2: Assess barriers for provider adoption, and pursue resources and opportunities to overcome those barriers.</p> <p><b>Goal 3: Enable the electronic exchange of health information</b> Objective 3.1: Develop a statewide health information exchange. Objective 3.2: Support the enhancement of network capacity and access to allow providers to connect and exchange information through the statewide HIE. Objective 3.3: Enable inter-state health information exchange.</p> <p><b>Goal 4: Enable the exchange of clinical data</b> Objective 4.1: Establish a statewide provider directory. Objective 4.2: Enable secure messaging among providers. Objective 4.3: Enable interoperability between laboratories and providers. Objective 4.4: Increase adoption of e-Prescribing in provider practices and clinics. Objective 4.5: Enable the exchange of continuity of care documents (CCD). Objective 4.6: Enable the use of the HIE to collect immunization data.</p> <p><b>Goal 5: Safeguard privacy and security of electronic health information</b> Objective 5.1: Identify privacy and security barriers and formulate strategies to address those barriers. Objective 5.2: Develop a privacy and security framework. Objective 5.3: Establish trust agreements with participating providers. Objective 5.4: Establish oversight to ensure compliance with privacy and security policies.</p> <p><b>Goal 6: Advance coordination of activities across state and federal government</b> Objective 6.1: Harmonize Iowa e-Health activities and Iowa Medicaid Enterprise health IT planning. Objective 6.2: Build an appropriately trained, skilled health IT workforce. Objective 6.3: Align health IT project activities with federally funded, state-based programs. Objective 6.4: Align project activities with federal care delivery organizations. Objective 6.5: Align project activities with other American Recovery and Reinvestment Act (ARRA) programs. Objective 6.6: Ensure coordination between Iowa and neighboring states. Objective 6.7: Align Iowa e-Health with broader health care reform efforts.</p> <p><b>Goal 7: Establish a governance model for statewide health information exchange</b> Objective 7.1: Explore governance options and establish a governance entity. Objective 7.2: Establish policies and procedures to govern operations of Iowa e-Health and the statewide HIE. Objective 7.3: Engage in multi-stakeholder, public-private collaboration.</p> <p><b>Goal 8: Ensure sustainable business and technical operations for health IT</b> Objective 8.1: Provide resources and project management to carry out Iowa e-Health goals, services, and activities. Objective 8.2: Provide resources and program management to sustain Iowa e-Health goals, services, and activities.</p>
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**Goal 9: Secure financial resources to develop and sustain a statewide HIE**

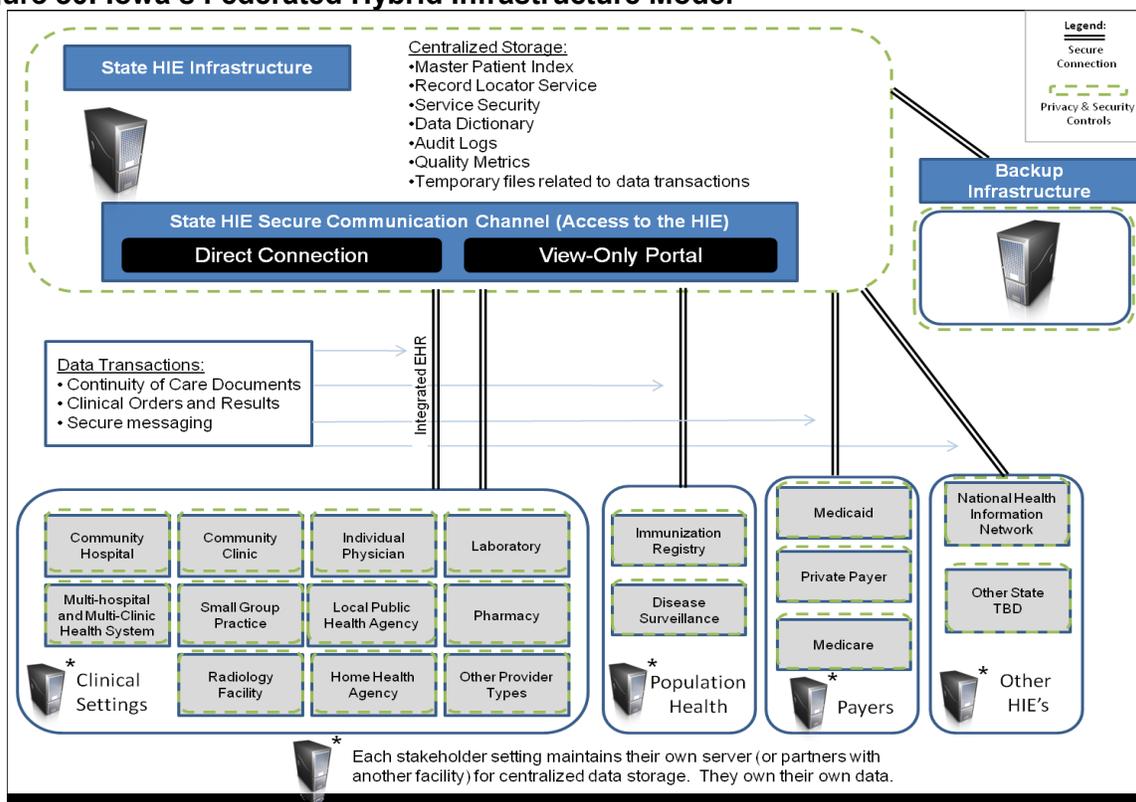
- Objective 9.1: Establish a BFSP to inform strategies for statewide HIE services and operations, provide financial projections, and identify financial strategies to enable sustainability.
- Objective 9.2: Execute financial strategies to develop, implement, and maintain a statewide HIE.
- Objective 9.3: Be fiscally responsible with all funding revenues and expenditures.
- Objective 9.4: Hold vendors accountable to achieve deliverables.
- Objective 9.5: Implement financial policies, procedures and controls as required by the state HIE cooperative agreement program.

**Goal 10: Monitor and evaluate health IT progress and outcomes**

- Objective 10.1: Conduct a baseline environmental scan.
- Objective 10.2: Develop an evaluation plan to determine whether changes in health care quality, safety, efficiency, and population health have occurred as a result of health IT.
- Objective 10.3: Perform comprehensive evaluations of Iowa e-Health.

Informed by stakeholders as part of the e-Health executive and advisory groups, the SOP Goal 2 reflects priorities for promoting statewide deployment and use of electronic health records, responding to the need to provide alternative, interim health IT solutions for providers unable to implement an EHR system and maintain a direct connection with the statewide HIE (including solutions such as EHR hosting, EHR-light, and a view only portal). Goal 3 describes strategies for implementing electronic exchange of health information, calling for the Iowa Health Information Network to utilize a federated hybrid model with a centralized master patient index, record locator service, auditing, secure messaging, and translation services where appropriate. The structure would allow for point to point messaging, query/response, and publish/subscribe technology.

**Figure 30: Iowa's Federated Hybrid Infrastructure Model**



## Implementation

In 2012, IDPH selected a vendor to build the IHIN infrastructure and capacity to support Direct Secure Messaging was implemented in December 2012. Since then, 57 organizations signed Participation Agreements which represents 16 hospitals and over 809 users as of August 2, 2013. IHIN and IME worked with providers, particularly dentists, in SFY13 to sign up and use this function to send prior authorization requests and clinical quality measures. Late in 2013, query and look-up functionality will go live and incrementally expand beginning with hospitals. Five hospitals are currently engaged in testing the query function with a go live launch anticipated in November 2013. Iowa Medicaid plans to utilize the publish/subscribe technology to capture quality metrics for verification of meaningful use and medical home performance payments. IME procured a quality metrics capture tool for both the meaningful use and the health home programs and is working with IHIN on a plan for implementation.

## Multi-State/Border State HIEs

Iowa shares borders with Minnesota, Wisconsin, Illinois, Missouri, Nebraska, and South Dakota. Currently, Nebraska's Health Information Initiative (NeHII) supports sharing Continuity of Care Documentation, lab, image, and discharge instructions across a wide provider base in the Omaha, NE/Council Bluffs, IA area (Mercy Hospital in Council Bluffs, IA; Mercy Hospital in Corning, IA; Community Memorial Hospital in Missouri Valley, IA; and Cass County Health System in Atlantic, IA with an implementation

pending in Red Oak, IA for the Montgomery County Memorial Hospital.) More information on NeHII can be found on their website, <http://www.nehii.org/>. In addition, IHIN is supporting Direct Secure Messaging between Iowa and Missouri, Illinois, Wisconsin, South Dakota and Minnesota.

## **Broadband Access**

Goal 3 of the strategic and operational plan (i.e. “Enable the Electronic Exchange of Health Information”) addresses the need for adequate broadband access speeds across Iowa to support health care information exchange by Iowa providers.

UnityPoint Health under its legal name, Iowa Health System received \$17,714,919 for their Iowa Healthcare Plus Broadband Extension Project. This project proposes to make significant upgrades to the health system’s existing 3,200-mile fiber network that services over 200 healthcare facilities across the state and bolster their wireline capabilities with wireless technology.

The IME, as an active participant on Iowa’s e-Health Council, will continue to support and leverage this and all grant opportunities available for the expansion of Iowa broadband network as described in the Strategic and Operational Plan.

## **State Immunization & Public Health Surveillance**

Connection to the Iowa Immunization Registry Information System (IRIS) has been identified as a priority service for the IHIN by provider organizations. In the absence of the ACA funding, Iowa sought and received HITECH funding to support connecting IRIS to the Iowa e-Health systems.

The IDPH received \$573,833 as part of the lab surveillance grant, approximately one-half the requested grant amount to begin the process of upgrading the Iowa Disease Surveillance system (IDSS) to accept electronic laboratory reporting. Iowa received HITECH funds to fill the \$500,000 gap in funding needed to complete this project. As of May 2013, The Iowa Department of Public Health had the capacity to receive immunization data electronically from electronic health records.

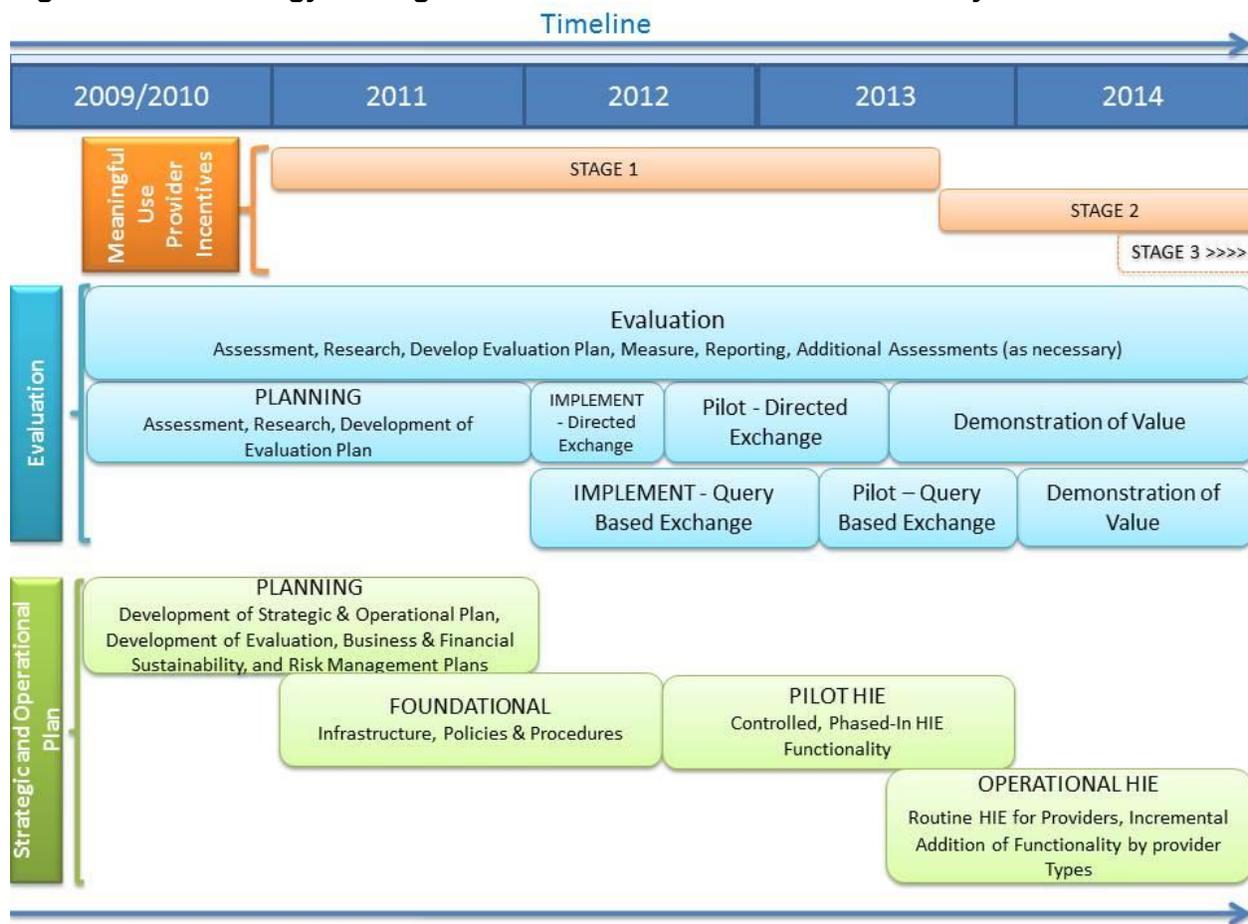
## **To Be – Expanding and Enhancing the Capacity of Iowa’s Health Care Information Systems to Support Accountable Care**

Iowa’s vision is to continue to build incrementally upon its strong e-Health foundation for stakeholder engagement, collaborative planning and policy provisions fostering HIT adoption and HIE development. While priorities include continuing to build basic HIT and HIE capacity among providers not yet implementing EHR systems or hosted functionality, emphasis is also on targeted HIE development efforts to enhance information system supports required for accountable care. These efforts align with Iowa Health and Wellness Plan objectives and milestones for ACO implementation.

Iowa intends to continue to rely upon the ongoing convening of the eleven advisory councils established by the 2008 Iowa health reform legislation. To ensure alignment among these councils for eHealth planning and implementation, IDPH plays an important role to coordinate regular health care reform connections and integration team meetings to foster close alignment with IDPH, IME and IHIN efforts and priorities.

Achieving the goals and addressing the recommendations from health reform advisory councils, particularly the Medical Home System Advisory Council and the Prevention and Chronic Care Management Advisory Councils, will be directly impacted by continued successful planning and implementation of EHRs and a statewide HIE. Health IT must enable providers from many disciplines to share information about a single patient and allow for more informed and coordinated care planning and service delivery. Iowa's reform strategy relies upon information system capacity to enable a shift in work flow and more informed health care decision making. This in turn is expected to lead to improved patient outcomes, increased quality of care, and reductions in the need for costly and redundant procedures or hospitalization.

**Figure 31: Technology Strategies and Priorities for HIE and Data Analytics**



Following the goals, strategies and objectives outlined in the Iowa Strategic and Operations Plan (SOP) for HIT and HIE implementation (highlighted in the following table), IHIN is continuing to pursue a multifaceted technology strategy to enable more robust connectivity by various means, designed to accommodate the types, locations and HIT capacity of Iowa providers. As stated in the SOP, ongoing priorities for connecting providers to the statewide include:

- Providers utilizing the services of the Iowa REC
- Physician offices and clinics (with 10 or fewer professionals)
- Physician offices and clinics (those with 11 or more professionals)
- Acute care hospitals
- Critical access hospitals
- Community and rural health centers and
- Specialty hospitals and clinics

The Implementation Schedule laid out in the SOP remains a viable view for how IHIN is pursuing incremental efforts to build statewide HIT and HIE capacity.

**Figure 31: Implementation Schedule**

SFY13 July 1, 2012 – June 30, 2013	SFY14 July 1, 2013 – June 30, 2014	SFY15 July 1, 2014 – June 30, 2015
<ul style="list-style-type: none"> <li>• Secure messaging</li> <li>• Submission of quality metrics</li> <li>• Continuity of Care Document (CCD)</li> <li>• Advanced clinical and quality reporting</li> </ul>	<ul style="list-style-type: none"> <li>• All services from SFY2013</li> <li>• Reporting to immunization registry information system (IRIS)</li> <li>• Electronic reporting to the Iowa Disease Surveillance System (IDSS)</li> </ul> <p>*HealtheWay Network Connectivity</p>	<ul style="list-style-type: none"> <li>• All services from SFY13 and SFY14</li> <li>• HealtheWay Connectivity</li> </ul>

Moving forward, Iowa’s eHealth stakeholders recognize that accountable care systems require more robust capacity for real time data exchange and data analytics at the point of care, as well as for proactive predictive modeling and population based health risk management. The phased implementation of the statewide HIE continues to focus on ensuring different methods for accessing the statewide HIE. Early efforts targeted a Web-based provider portal for access to the provider directory, quality reporting tools integrated into the portal, and Direct Secure Messaging connections to enable providers to access the provider directory. Supporting this basic capacity remains important, especially considering the number of small provider practices especially in rural areas across Iowa where the ability to implement robust EMR systems and HIE connection is likely to remain more limited.

Into the future, IHIN is focused on additional aspects of Iowa's SOP that relate to supporting accountable care.

- **Building out Iowa's hybrid federated HIE infrastructure** will enable cross-community connections between larger HIE environments, thereby by linking several "medical neighborhoods" across the state ((1) northeast (2) north central, (3) northwest , (4) southeast, (5) south central, and (6) southwest).<sup>98</sup>

IHIN is working with each of the four large health systems in the state to sign participation agreements and incrementally implement, test and go live with connectivity between systems (i.e. as Health Information Service Providers (HISPs) for Direct Secure Messaging, using the IHIN supported central Master Person Index). The four hospital-based systems are using certified EHR products which support Direct Messaging and the ability to exchange Continuity of Care Document (CCD) records, as are numbers of ambulatory care providers within the medical neighborhoods surrounding these hospitals in metropolitan areas of Iowa. The health systems constitute the Integrated Delivery Networks/ACOs connected with Wellmark (i.e. University of Iowa Health Alliance, Iowa Health Accountable Care d/b/a UnityPoint Health Partners, Mercy, and Genesis). While the systems and provider networks have exchanged information internally, they are now working with IHIN to explore organization-to-organization information exchange.

- **Building data analytics capacity.** As part of IME's health home implementation, providers are required to participate in IHIN and use Direct to send CCD documents to a CCD repository hosted by IHIN for the IME. The CCD repository will blend administrative and clinical data and enables population based analytics using the Alere Health Solutions tool. Health Homes that meet the quality thresholds for the quality metrics through the data submitted via the IHIN will earn an annual performance bonus. The data will be available on a real time basis for the Health Home providers and their managers. Their data is then compared to the overall states statistics.
- **Expanding query-based exchange and real time notifications.** IHIN's HIE vendor, Informatics Corp of America, supports Direct Exchange as well as query based exchange. Recognizing that real time data is necessary to optimize care coordination and transitions of care, IHIN is preparing to offer the same infrastructure currently supporting the IME Health Home initiative to other ACOs. This includes being able to support near real time notifications of admissions, discharges and alerts (ADTs) to participating providers.
- **Ensuring HIE connectivity for any smaller providers with limited IT capacity.** IHIN recognizes that many smaller community based provider types and organizational entities (e.g. Physical therapy, home health, and long term care facilities) will not likely implement robust EHR systems that are capable of exporting CCDs. IHIN anticipates continuing to support these providers with other

strategies like a hosted shared EHR-light, portals, and more limited HL7 exchange.

## Medicaid HIT Strategies and Roadmap

The IME is an active participant in Iowa’s eHealth efforts, and its strategies and priorities are integrated as part of Iowa’s overall HIT and HIE implementation. In conjunction with the SOP submitted by IDPH, IME has formulated a set of goals and objectives and developed a roadmap to address Medicaid specific priorities for HIT and HIE development into the future.

### The IME HIT Plan and Roadmap

IME’s HIT planning and roadmap center around four goals central to supporting the health of Medicaid populations and Iowa’s overall reform goals and SHIP. These goals and objectives, as articulated in the IME’s State Medicaid HIT Plan (SMHP) most recently submitted and approved by CMS, are summarized below.

Increase provider

The goals are to:

- r adoption of electronic health records and health information exchange
- Improve administrative efficiencies and contain costs
- Improve quality outcomes for members
- Improve member wellness

### SMHP Objectives and Roadmap Action Priorities

The following table summarizes the IME HIT and HIE objectives and priorities for action moving forward that correlate with other eHealth and IHIN efforts.

**Figure 33: Objectives and Roadmap Priorities**

Objectives	Roadmap Priorities
<p><b>1. Increase provider adoption of electronic health records and health information exchange</b></p> <p>1.1. Support HER Incentive program eligible providers to capture and exchange electronic information</p> <p>1.2. Support IHIN and nationwide connectivity model (NeHIN)</p> <p><b>1.3.</b> Support adoption/HIE for providers not eligible for the HER Incentive Program</p>	<p>1. Increase provider adoption of electronic health records and health information exchange</p> <ul style="list-style-type: none"> <li>- Administer the Medicaid EHR Incentive Payment Program (In progress, latest summary included below)</li> <li>- Fill EHR Technical Assistance Gaps</li> <li>- Classes for credit through local community colleges (Planning for Fall 2014)</li> <li>- Annual Training (Happens annually in Summer)</li> <li>- eHealth Summit (Annual) (10<sup>th</sup> annual this year)</li> </ul>
<p><b>1. Improve administrative efficiencies and contain costs</b></p> <p>1.1. Use IHIN and HER infrastructure to provide information for providers</p> <p>1.2. Use IHIN/eliminate faxing and paper</p>	

Objectives	Roadmap Priorities
<p>exchange</p> <p>1.3. Provide IHIN access to targeted providers where quality improvements will yield cost containment for Medicaid</p>	<p>2. Support health information exchange</p> <ul style="list-style-type: none"> <li>- Financial Support (Ongoing)</li> <li>- Participate in eHealth Council(Ongoing)</li> <li>- IME policy levers to encourage providers' participation (currently required for Health Homes; to be required by ACOs)</li> <li>- Medicaid Prior Authorization through Direct Secure Messaging (ongoing for dentists)</li> </ul>
<p><b>2. Improve quality outcomes for members</b></p> <p><b>2.1. Improve care transitions between provider settings.</b></p> <p><b>2.1.1. Decrease hospital readmissions from Long Term Care Facilities. Provide Discharge Instructions and Continuity of Care information real-time from Hospitals to LTC via EHR &amp; HIE adoption.</b></p> <p><b>2.1.2. Decrease LTC readmissions from Home Health Services. Provide Discharge Instructions and Continuity of Care information real-time from LTC to Home Health Services via EHR &amp; HIE adoption.</b></p> <p><b>2.1.3. Support patient/home health collection of relevant vitals via HIE patient/home health portals.</b></p>	<p>3. Evaluate strategies to expand the availability of health records for providers and members</p> <ul style="list-style-type: none"> <li>- To support prior Authorization, Program Integrity, EHR incentive processing, and other functions (strategy on hold)</li> <li>- Support for Long Term Care and Home Health Organizations to use Continuity of Care and Discharge Instructions from hospitals and providers.</li> <li>- Provide Medicaid Members with an electronic personal health record to distribute wellness education, and alerts/reminders for preventative care and disease management.</li> <li>- Support additional people in the care management team of the member, such as school nurses, social workers, care coordinators, foster parents, and others as determined necessary.</li> </ul>
<p><b>3. Utilize Health Information Technology to expand the application of evidence based treatment.</b></p>	
<p><b>4. Capture Quality Measures for monitoring provider performance.</b></p> <p>4.1. Determine if correlations between quality measures and underserved populations exist.</p>	
<p><b>5. Improve member wellness</b></p> <p>5.1. Provide members with information regarding their personal health.</p> <p>5.2. Provide Medicaid member's care teams with clinical information.</p> <p>5.3. Provide members with wellness education.</p> <p>5.4. Create a Medical Home model that promote healthy outcomes and manages the member's chronic health conditions</p>	<p>4. Support Medical Home/Health Home and Meaningful Use of Exchanged Information</p> <ul style="list-style-type: none"> <li>- Health Home use of Direct (Ongoing)</li> <li>- Improve access to clinical Information during Transitions of Care</li> </ul> <p>5. Capture Quality Measures Data</p> <ul style="list-style-type: none"> <li>- Receive Quality Measures Data (portal available, resolve tech barriers for providers)</li> <li>- Deliver education and interventions</li> </ul>

The IME plans to continue to actively participate as part of the eHealth Advisory Council and with IHIN to foster attention to the Roadmap priorities through the following activities.

**Table 29: Roadmap Priorities for SFY 2014**

SFY14	Action
<b>Support Adoption of EHR</b>	Continue to administer the EHR Incentive Program.
	Update attestation and program administration for meaningful use stage 2.
	Evaluate and assess the success and progress of the EHR incentive program and Medicaid provider’s use of electronic health records.
	Provide technical assistance to providers to transition to the meaningful use of electronic health records.
<b>Support Health Information Exchange</b>	Participate in council and workgroup meetings of the e-Health project.
	Provide technical and financial assistance to support connectivity between public health reporting systems and the HIE.
<b>Expand the Availability of Health Records</b>	Continue to expand the usage of the Web Portal to members of the care team.
	Explore opportunities for health IT with the implementation of ACA mandates
	Plan for integration of personal health records and quality alert messages to Medicaid Members.
<b>Support Medical Home &amp; Meaningful Use</b>	Review the rules for Medical and Health home and update as appropriate to increase the meaningful use of EHR.
<b>Capture Quality Data</b>	Analyze quality data looking for performance and education opportunities.

### **HIT and HIE Innovation Challenges and Priorities**

Iowa has benefitted from its level of sustained stakeholder engagement, buy-in and collaborative development of the state’s eHealth initiative, HIT and HIE strategies. With a consistent and inclusive governance framework, Iowa has been able to move forward systematically to align planning, policy supports and technology development, beginning with a realistic assessment of the health care landscape then leveraging resources for HIT adoption and HIE development. In its technology planning, IHIN has taken advantage of Direct messaging as a near term solution for connectivity, while moving forward to build more robust interoperability with query based exchange. Support for analytics has begun through the state’s health home implementation, for which IHIN is supporting a CCD repository.

These efforts have positioned Iowa favorably, compared with many states, to be able to expand information supports for delivery system and payment reforms.

That said, Iowa faces the same challenges and barriers that are also prevalent in other states.

- A two-fold challenge comes from relying on diverse EHR vendors to carry out their EHR product implementations and build HIE interfaces for their products. IHIN continues its efforts to work with the Regional Extension Centers (REC) and prevalent vendors, however vendor capacity, business models and performance influence the pace and quality of provider EHR information system implementations. Subsequently, the pace and processes for achieving HIE onboarding and go-live status also become delayed.
- Another major issue is finding the resources necessary to achieve critical mass in terms of the types and numbers of providers who have electronic record systems and are connected to HIE. Iowa has made significant progress engaging providers to participate in the EHR Incentive Program and initially attest to AIU. Among states, Iowa has a relatively high rate of providers returning to attest to Meaningful Use. However, this represents less than half of the initial EHR adopters who have returned to demonstrate capacity for meaningful use. A widely recognized challenge is for providers to have continued supports that help them integrate the use of EHR systems into their flow of care and use their systems effectively. Concerted efforts are necessary to help providers understand the functionality and becoming proficient with using it. To date, Iowa's REC has played an important role promoting EHR adoption, however the ONC grant funding for the REC program is nearing its end and a new business model for providing REC services must be implemented. As part of accountable care, a wide array of community based providers, including home health and long term care facilities- require HIE connectivity to foster coordination of care. Another major resource issue is the lack of resources to finance IHIN building the interfaces from provider EHR products to the HIE.
- Related to the above, Iowa faces issues to build HIT and HIE solutions for providers in rural areas. Unlike the major health systems in Iowa's more metropolitan areas, providers in rural counties lack organizational affiliations with hospitals, offering the resources to help sponsor HIT and HIE capacity building. Further, some rural providers may lack the IT infrastructure, including broadband internet access, to connect to the IHIN.
- To meet Iowa's accountable care goals, a diverse array of community based providers, such as home health providers and long term care facilities, need the capacity to exchange real or near real time health information data. IHIN anticipates that to serve many of these providers, especially in rural areas, it will be necessary to build out edge environments for HIE using at least basic HL7 messaging.
- Addressing Iowa's goals for shifting to accountable care requires increasing provider, health system and payer capacity for data analytics. The current IHIN technology architecture does not call for a centralized registry, although it can

support multiple “mini-registries” that might be associated with various health system HIE hubs. IHIN has developed a database to serve as a registry to support the start of the IME health home program, and this registry size and functionality has the potential to be expanded. While on one hand it makes sense to centralize repository functionality to support all of the state’s ACOs with population based analyses, there has been a historic reluctance in Iowa to have centralized data stores housed within state government. Further discussion and strategy development is needed to address data analytics capacity for expanding accountable care in Iowa.

Iowa’s HIT and HIE implementation efforts to date have been grounded upon a well-functioning structure and processes for stakeholder collaboration, prioritization and use of resources. The systematic approach to capacity building that has been demonstrated to date is key to achieving the goals and strategies articulated in Iowa’s Innovation Plan for expanding accountable care for all Iowans. IHIN is poised to implement expanded HIE connectivity following its pilot of query based exchange, and its experience implementing the IME’s Health Home program. Iowa Medicaid has and will continue to play a pivotal role to support the adoption of the HIT, HIE connectivity and informed care management decisions; the IME will require ACOs participating in the Wellness Plan starting January 1, 2014 to both connect to IHIN for Direct Messaging and query capabilities, and to work collaboratively with the State in exchanging real-time notifications (Admission, Discharge, Transfer or “ADT”) as this functionality develops. As the RFP process for contracting with ACOs is put into motion, Iowa Medicaid intends to align its strategies for fostering HIT and HIE capacity by incorporating similar requirements.

Developing data analytics capacity is an important priority for the IME. As part of the SIM stakeholder process, the development of an enterprise solution for an all payer claims database was discussed, generating initial support from provider organizations.

Overall, steps to formalize Iowa’s Innovation plan will take advantage of the opportunity to strategically target resources to build out the HIT and HIE capacity where accountable care systems can most readily be implemented. At the same time, plans to address the variable HIT and HIE needs of providers and medical neighborhoods across the state will be implemented as resources are available, in order to broaden accountable care implementation across Iowa.

## **7. “As Is” of Iowa's Health Care Delivery System Models and Payment Methods**

**(Responds to First Parts of Questions 4 and 6 and all of Questions 14 and 15)**

Iowa’s healthcare system has many strengths. There are also many opportunities to improve upon the health of Iowans, the delivery of care, patient satisfaction with care, and the efficiency of care. This section provides an overview and details about Iowa’s existing health care system with a focus on the delivery system models and payment

methodologies' strengths and opportunities. The second half of the response to this question provides information on the "to be" state of the health care system.

In Iowa, more adults have a usual source of care than nationally, and more children have a medical home. Preventable hospital admissions are lower than the national average, for both adults and children, as are avoidable uses of the Emergency Room. Medication compliance in Iowa is higher than the national average and Iowa's percentage of low birth weight births is lower than the national average.

Another strength, as mentioned earlier, is the lower than average rate of uninsured (11% vs. 16%).

Iowa's health care system is characterized by a relatively small number of large entities that are already working together. Three payers (Wellmark, Medicaid and Medicare) provide coverage to a vast majority of Iowans (86%) and a small number of very large integrated health systems deliver the majority of acute care services and employ more than half of the primary care physicians in the state.

## **Hospital Engagement Network**

The recently launched national Partnership for Patients Initiative was developed to make health care safer and less costly by targeting and reducing the millions of preventable injuries and complications from health care acquired conditions. The Partnership for Patients set the aims of reducing hospital acquired conditions by 40% and reducing preventable hospital readmissions by 20% by 2013.

Shortly after the launch, the CMS Innovation Center implemented the Hospital Engagement Networks (HEN), a nationwide public-private collaboration to identify and create innovative solutions designed to reduce patient harm and improve care coordination. The Iowa Healthcare Collaborative (IHC) is one of the 26 organizations awarded a two-year contract to help identify the key improvements and spread initiatives across their defined population. Iowa's hospitals rallied behind this call to action, with 100% of hospitals pledging their commitment to the Partnership.

Much of the work of the IHC HEN is focused on education and training of quality managers, hospital teams, and supporting the work of line staff in the improvement effort. The State will work closely with the IHC HEN to collaborate on conferences and meetings to provide training and guidance on health homes, ACO concepts, and promoting a more accountable health care system. The IHC HEN also recognizes that it is paramount to align and equip hospital leadership to lead change improvement efforts and these activities will be collaborative with IME to further the goals of the SIM. A recent systematic review found that, in general, leadership was the most effective organizational characteristic associated with hospital quality improvement outcomes. The 2010 National Quality Forum Safe Practices specifically targets the importance of top-level leadership in driving a culture of quality and safety. The IHC HEN is working with leadership to set the tone for the effort, provide resources, monitor performance,

and provides ongoing encouragement for success of the initiative. Specifically, the IHC HEN program will facilitate hospital leadership engagement by:

1. Asking each enrolled CEO to complete a brief leadership structures and systems survey. The survey will be repeated annually to help determine the effectiveness of training and other support from the IHC HEN on the engagement of the hospital's leadership and Board.
2. Integrating training on culture of safety leadership in its Learning Communities and IHC/Iowa Hospital Association venues.
3. Providing technical assistance support and leadership content for hospitals requesting educational assistance.

## Medicaid

Iowa's Medicaid program is managed by the IME, which oversees the program and reimburses providers and facilities for Medicaid services in the State. In SFY 2012, IME employed 26 full time staff, employed 12 Health Insurance Premium Payment staff, and held nine contracts with private vendors. The IME performs policy functions and vendor management while vendors are assigned operational roles such as claims processing, member and provider engagement, and quality assurance.

The Medicaid system in Iowa includes multiple delivery and payment system models. In the Medicaid system, the majority of Medicaid enrollees are served in a managed Fee-for-service (FFS) system—the MediPass program, a primary care case management program that is supplemental to the FFS model—for their physical health care. However, a capitated managed care option for physical health care exists in some counties. Individuals with chronic illnesses are enrolled in health homes (sometimes called the Primary Care Health Home) and there is a new Integrated Health Homes program for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). All of these models are described in detail below, along with information about existing efforts in Iowa to transform the physical health, behavioral health and LTCSS systems.

### Physical Health Care

#### Fee for Service System

For physical health care, the majority of Medicaid enrollees are served in a FFS system which had 375,000 enrollees in 2013. All TANF Medicaid members who are eligible for full Medicaid and are in a region served by MediPASS are required to enroll (if in a county served by Meridian Health Plan (described below) the member can select the capitated, full-risk program). MediPASS enrollees must select a primary care provider (referred to as a patient manager (PM)). If an enrollee does not select a PM, a PM is assigned to the enrollee by the State. Individuals have 90 days to make a change to their PM, otherwise they must remain with that PM for six months (certain exceptions do apply). The primary care provider makes referrals for services that require a referral and serves as the sole point of access into the healthcare system. The PMs are required to

have a single 24-hour access phone number for scheduling appointments, accessing information, and for use by members when the office is closed. PMs are reimbursed FFS for services and also receive an administrative fee of \$2.00 PMPM for each member enrolled with the PM. FQHCs are reimbursed their clinic-specific encounter rate and do not receive the administrative fee for individuals who are enrolled with them. While the MediPASS program is a good step toward providing more integrated and coordinated care, it is only a first step. The MediPASS program is not statewide, and not all providers across Iowa are able to meet the requirements of serving as a PM.

IME pays its providers using fairly traditional reimbursement methodologies that encourage the status quo and reward volume of services rather than value of services.

As examples:

- Inpatient hospitals are paid based on a prospective reimbursement system based on diagnosis-related groups (DRGs); physical rehabilitation and psychiatric units as well as rehabilitation hospitals are paid a per diem rate;
- Outpatient hospitals (general, in and out-of-state) are paid prospective reimbursement system based on ambulatory payment classification;
- Skilled nursing facilities are paid a modified risk-based case-mix adjusted per diem (must be Medicare-certified and provides only skilled level of care and swing-bed hospitals);
- Home health agencies are reimbursed on a prospective FFS methodology based on Medicare Low Utilization Payment Adjustment (LUPA) rates (until July, 2013 reimbursement was cost-based with not to exceed established maximums and interim payments based on a percent of charges).
- Intermediate Care Facilities for individuals with Mental Retardation (ICF/MRs) are paid a per diem rate capped at 80<sup>th</sup> percentile;
- Rural Health Clinics (RHC) and FQHCs receive cost-based reimbursement with cost settlement. For both groups the interim payment is based on an "all-inclusive" visit rate. Wrap-around payments can be made based on Health Maintenance Organization (HMO) utilization and payment information submitted by the provider. Wraparound payments are subject to cost-settlement; and
- Nearly all non-institutional providers are paid according to a fee schedule based on resource-based relative value scale (RBRVS) (hospice and clinical social workers are among the exceptions).

### Managed Care - Meridian Health Plan

An alternative to the FFS system in some counties is Meridian Health Plan, a privately owned, physician-managed Medicaid health plan. Meridian aims to “function as a care management and preventative care organization with an emphasis on disease management.” It has also made HEDIS improvement a corporate priority. Over the past several years, Meridian has been expanding its service area into additional counties. Currently, there are just under 40,000 Medicaid members enrolled. Meridian has been working closely with the State during the planning for and implementation of the Iowa Health and Wellness Plan. Together the State and Meridian are identifying ways in



The program is open to any full benefit Medicaid member, adult or child, and targets individuals with chronic physical conditions and co-morbidities with mental illness. As defined in Iowa’s State Plan Amendment, individuals are eligible if they have at least two chronic conditions or one chronic condition and are at risk for developing a second. The targeted chronic conditions are:

- Mental Health Condition
- Substance Use Disorder
- Asthma
- Diabetes
- Heart Disease
- BMI Over 25
- Hypertension
- BMI Over 85 Percentile for Pediatric Population

The Health Homes are paid a per-member-per-month (PMPM) rate based upon the number of chronic conditions of the member, in addition to the regular fee for service payments:

**Table 30: Health Home PMPM Payments**

Tier	PMPM
Tier 1 (1-3 chronic conditions)	\$12.80
Tier 2 (4-6 chronic conditions)	\$25.60
Tier 3 (7-9 chronic conditions)	\$51.21
Tier 4 (10 or more chronic conditions)	\$76.81

The Health Home model and the accompanying payment enable providers to offer additional services for members with specific chronic conditions. In order to participate in the Health Home program, IME requires that providers meet specific standards and seek patient-centered medical home (PCMH) recognition within 12 months of enrolling in the program. To facilitate a team-based, community-focused approach, providers participating as a Health Home must connect to the Iowa Health Information Network (IHIN).

In addition to improving health outcomes, Iowa had estimated that the Health Home program will save between \$7 million and \$15 million in state dollars in the first three years of implementation. However, this estimate was based on enrollment numbers in excess of the current enrollment of about 4,000 Medicaid clients. To ensure that all Medicaid members that could benefit from the more coordinated services provided by a Health Home are enrolled and that savings are realized, the State is initiating a more concentrated and focused effort to expand enrollment. This effort includes additional outreach to providers with a particular focus on providers needing more support to meet the health home requirements. Initially, in order to get the program in place, the State had worked with the more sophisticated providers. This concentrated effort will support more providers in not only becoming health homes or patient centered medical homes

but will also position these providers to take on greater accountability and risk as part of the statewide Medicaid ACO model.

The State has also implemented an Integrated Health Home (IHH) model for individuals with serious mental illness and children with serious emotional disturbances. The IHH initiative is described in the Behavioral Health Delivery System section.

### **Long Term Care Supports and Services (LTCSS)**

Another major component of Medicaid is the delivery of LTCSS. Medicaid is the primary payer of LTCSS in the State and payment for these services consumes more than half of the Medicaid budget. The system includes both institutional and community-based services. There are currently just under 12,000 people in nursing facilities and approximately 30,000 enrolled in one of the following HCBS waivers:

- HIV/AIDS (34 enrolled with no waitlist)
- Brain Injury (1,281 enrolled with 175 in process and 812 people on the waitlist)
- Children's Mental Health (919 enrolled with 177 in process and 1,615 people on the waitlist)
- Elderly (9,101 enrolled with no waitlist)
- Health and Disability (2,365 enrolled with 311 in process and 2,623 on the waitlist)
- Intellectually Disabled (12,354 enrolled with no waitlist)
- Physical Disability (917 enrolled with 209 in process and 2,011 on the waitlist)

Services vary by waiver but everyone receives service coordination and a comprehensive service plan. Workgroup members indicated that because not all services are included in all waivers, enrollees often go without needed services (that is they are enrolled in a waiver that doesn't include a service they need).

As with medical care, the majority of LTCSS reimbursement methodologies incentivize volume rather than value. Nursing facilities are paid a modified price-based case-mix adjusted per diem and the residential care facility methodology is cost-based with a cap. HCBS waiver providers are paid negotiated rates, retrospectively limited prospective rates and based on a fee schedule. For habilitation services, IME reimburses services using a cost-based methodology with fiscal year end cost settlement at 100% of costs not to exceed the established limits. Effective July 2013, these services are being paid for by Magellen as part of the requirements under the Iowa Plan.

### **Balancing Incentives Payment Program**

A part of the reformation of LTCSS delivery system in Iowa is the Balancing Incentive Payment Program (BIPP). Effective July 1, 2012, the State of Iowa is the recipient of a three-year BIPP grant from CMS. BIPP is designed to "balance" states' spending on long term supports and services and one goal is to assist states in increasing the percent of LTCSS expenditures for community based long term support services. As of June 2013, Iowa spends approximately 48.6% of its Medicaid LTCSS funds on HCBS.

The projection for 2015 is that the rate will be 50.02%. Other overarching goals of the BIPP are to create coordinated access to LTCSS through development of a statewide integrated system (No Wrong Door), development of Core Standardized Assessments to ensure that all assessments will be administered in a standardized fashion throughout the State, expanded use of cost effective community based long term services and supports, and support and improve quality measurement and oversight. Through the BIPP grant, Iowa is receiving an enhanced match rate of 2% for non-institutional long term services and supports, for a total of \$61.8 million.

The Federal requirements to achieve the BIPP goals are:

- A No Wrong Door/Single Entry Point system for, at a minimum, Home and Community Based Services and Long Term Services and Supports
- Conflict free case management: that optimally includes the following design elements:
  - Clinical or non-financial eligibility determination is separated from direct service provision. Case managers who are responsible for determining eligibility for services, do so distinctly from the provision of services. In circumstances where there is overlap, appropriate firewalls are in place so that there is not an incentive to make individuals eligible for services to increase business for their organization. Eligibility is determined by an entity or organization that has no fiscal relationship to the individual. This separation applies to re-determinations as well as to initial determinations.
  - Case managers and evaluators of the beneficiary's need for services are not related by blood or marriage to the individual; to any of the individual's paid caregivers; or to anyone financially responsible for the individual or empowered to make financial or health-related decisions on the beneficiary's behalf.
  - There is robust monitoring and oversight. A conflict free case management system includes strong oversight and quality management to promote consumer-direction and beneficiaries are clearly informed about their right to appeal decisions about plans of care, eligibility determination and service delivery.
  - Clear, well-known, and accessible pathways are established for consumers to submit grievances and/or appeals to the managed care organization or State for assistance regarding concerns about choice, quality, eligibility determination, service provision and outcomes.
  - Grievances, complaints, appeals and the resulting decisions are adequately tracked and monitored. Information obtained is used to inform program policy and operations as part of the continuous quality management and oversight system.
  - State quality management staff oversees clinical or non-financial program eligibility determination and service provision business practices to ensure that consumer choice and control are not compromised, both through direct oversight and/or the use of contracted organizations that provide quality oversight on the State's behalf.

- Core Standardized Assessments: standardized assessment tools identify eligibility for non-institutional services and supports and are used as a guide to develop person-centered service plans to address unique needs.

The work of the BIPP is in alignment with the work of the SIM, and the two grants and initiatives are mutually supportive. The work of the SIM includes a focus on the development of ACOs that have specific capabilities around improving care coordination and increasing the use of the most appropriate services in the most effective, appropriate, cost-effective, patient-centered settings, including increasing the use of home and community based services when this is most appropriate. Through the SIM work, ACOs will be held accountable for improving coordination of care and integration of services, and ensuring that individuals receive the most appropriate care and the most appropriate setting. The work of the BIPP to develop standardized assessments, no wrong door for services, and conflict-free case management standards and processes, to support the goals of ACO and expanded access to community based long term supports in a cost effective manner.

## **Behavioral Health Care**

Medicaid enrollees are mandatorily enrolled in the Iowa Plan, which uses a statewide Behavioral Health Organization (BHO) to provide behavioral health services. Magellan Health Services has held the contract since 1995. In addition to providing comprehensive mental health and substance abuse services to the Medicaid population (including telehealth services, integrated health homes, crisis intervention services, and peer supports) Magellan provides DPH-funded substance abuse services to individuals who:

- Are residents of the State;
- Have incomes at or below 200% FPL;
- Lack sufficient third-party coverage to pay the full billable cost of the service; and
- Are not a Medicaid beneficiary enrolled in the Iowa Plan

There are two different funding streams in the Iowa Plan, each with specific policies and procedures:

- Medicaid funding for mental health and substance abuse services is provided by IME and is based on enrollment. Magellan is paid a PMPM rate and is at-risk for the cost of Medicaid services. A specific, capped percent of Medicaid funding is set for Magellan's administrative costs.
- IDPH funding for substance abuse services is a set annual amount from federal block grants and state appropriations, regardless of the number of clients who present for services.

Upon design, the program included a requirement that 2.5% of Medicaid funding goes directly to a Community Reinvestment fund for enhancement or expansion of behavioral health services and supports. During SIM workgroup meetings attendees indicated they liked this component of the Iowa Plan and encouraged the State to consider a similar initiative as part of the SHIP that will fund activities that will result in longer-term savings

(i.e. investments in socio-economic factors that affect the health of children and will result in improved health and decreased in health care costs measured in decades rather than in year).

Magellan is responsible for paying providers in its network for the behavioral health services specified in the State Plan. Generally, Magellan pays providers on a FFS basis using rates that are approved by IME. For some providers, including the Psychiatric Medical Institutions for Children (PMICs) rates are reconciled against annual cost reports filed with DHS. Up until July 2012, PMICs were paid by IME. Since the transition, Magellan and these providers are currently negotiating fee for service rates that will eliminate cost based payments.

### Mental Health and Disability Redesign

The State is in the midst of a multi-year effort to redesign the mental health and disability services (MHDS) system in Iowa. Starting in 2011, multiple workgroups convened to develop recommendations and strategies to move the system from one that is county-based to one that is regionally-based and has consistent, performance-based contracts. Workgroups covered topics including, but not limited to: children's disability services; adult mental health services; adult intellectual and developmental disability services; brain injury services; and outcomes and performance measures. In 2011 and 2013, legislative interim committees met to review workgroup recommendations and to explore financial solutions for the MHDS system. In 2012, the Iowa legislature passed Senate File 2315: the Mental Health and Disability System Redesign Legislation. This legislation continued the workgroup process with a focus on supporting a transition in the system to a regional system based on outcomes and performance measures. This resulted in the Iowa legislature passing additional legislation in 2013 that supports the development of consistency, continuity, effectiveness, efficiency and accountability in the MHDS system.

In 2013, the State began work in earnest and is: providing guidance to providers, developing service definitions; developing rules and reimbursement methodologies; implementing a crisis stabilization pilot; and providing technical assistance. There is a Transition Committee that was formed to focus on the transition from a county-based system into a regional system. In its Final Transition Report the Committee reported that 96 counties are in the process of forming approximately 15 regions. The Report also included rules and requirements for counties that wish to be exempt from forming into counties of three or more. As of August 2013, only Polk and Jefferson Counties had requested an exemption.

The SIM work will build upon these transition efforts by using similar outcomes measures, ensuring partnerships between BH providers and ACOs, building from a community and regional approach, and continuing to work with BH stakeholders. The MH redesign process is a comprehensive, multi-year process that has involved multiple stakeholders. Because stakeholders and the State had gone through this process, the BH community was able to be active participants in the SIM design process. Both of

these efforts are focused on taking steps to simplify and strengthen the health care system, establish greater consistency in the quality and cost of care provided and establish approaches that encourage patient involvement

### Integrated Health Homes for Individuals with Serious Mental Illness

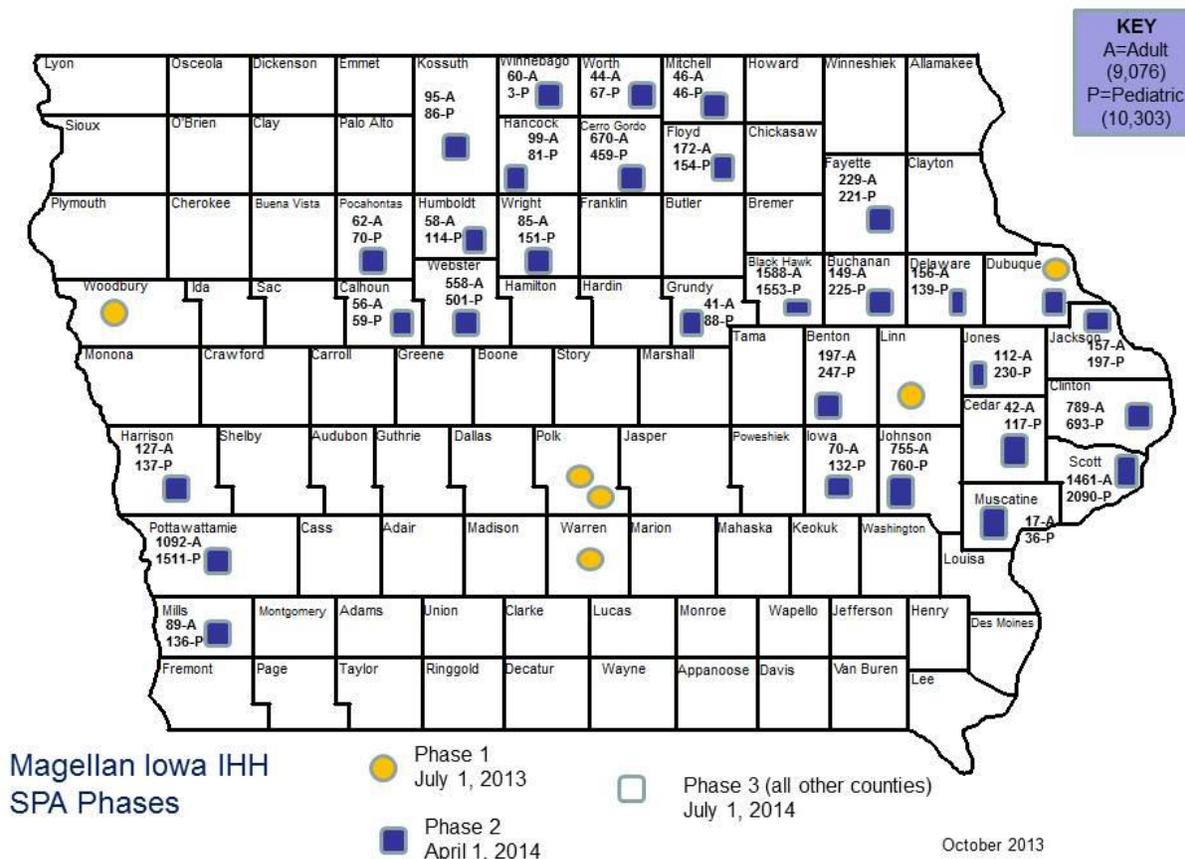
Starting on July 1, 2013, the State began serving adults enrolled in Medicaid who meet the criteria for Serious Mental Illness (SMI) and children enrolled in Medicaid who meet the criteria for serious emotional disturbance (SED) through an Integrated Health Home (IHH). Initially, there were IHHs in five counties (providers are included in parentheses):

- Dubuque (University of Iowa – Child Health Specialty Clinic for children only)
- Linn (Four Oaks, Tanager Place, Abbe CMCH)
- Polk (Eyerly Ball Mental Health Center, Broadlawns)
- Warren (Eyerly Ball Mental Health Center, Broadlawns)
- Woodbury (Siouxland Mental Health Center)

Effective October 1, 2013, the IHH program expanded to include:

- Polk/Warren (Lifeworks and Youth Emergency Services and Shelter for children/youth) (Community Services Advocate for transitional age youth (16-26)) (Orchard Place, children/youth)
- Dubuque (Hillcrest)

**Figure 35: Integrated Health Homes as of October 2013**



Additional IHHs will be added during 2014. At the time of the writing of the SHIP there are approximately 12,000 people who have an IHH helping them coordinate their care. After full implementation the State anticipates that nearly 25,000 people will be served in this program.

The IHH is a team of professionals working together to provide whole-person, patient-centered, coordinated care. The IHH is being administered by Magellan who is operating as the Health Home lead entity working with community-based IHH providers. The IHH providers are specially trained to provide comprehensive care coordination for individuals with SMI or SED. Providers include, but are not limited to, such entities as community mental health centers, federally qualified health centers, and child health specialty clinics. The IHH provides care coordination across all aspects of an individual's life, including but not limited to coordination of physical health care, successful transition from inpatient and residential treatment, and case management for rehabilitative services and access to peer and family support specialist. Through the IHH, the State has taken initial steps to integrate better physical and behavioral health care. For example, \$10 PMPM for each IHH enrolled member is paid to the primary care provider to support their time as a participant of the health care team. Also, the IHHs are bringing nurse care managers that have physical health care experience into their sites

for the purpose of identifying the need for and coordination of physical health care services.

Magellan pays the IHH providers for the more traditional BH services provided according to the terms of its contract with each provider. The team of health care providers is paid the following per-member-per-month payments to provide IHH services:

**Table 31: IHH PMPM**

Tier	PMPM
Tier 5 (Adult)	\$177.79
Tier 6 (Child)	\$153.38
Tier7 (Adult with Intensive Care Management)	\$397.79
Tier 8 (Child with Intensive Care Management)	\$373.38

The proposed SIM model design will build upon the IHH by leveraging relationships that are being developed and strengthened between behavioral health providers and physical health providers, by replicating the successful care coordination strategies that are being using by the IHHs that include an integrated team approach with peer support/family support, and lessons learned about how best to coordinate care for people with behavioral health needs.

## CHIP

Targeted low-income children in Iowa are covered by either the Medicaid expansion program or the Healthy and Well Kids in Iowa (*hawk-i*) program, which is a separate Children’s Health Insurance Program. Both programs provide a full array of health and dental services. The Medicaid expansion population is provided services from the State’s Medicaid program with the options available for Medicaid enrollees. The *hawk-i* population receives services from commercial managed care plans. The *hawk-i* program pays premiums to commercial insurers and the insurers provide benefits in the same manner as for their commercial beneficiaries. United Healthcare, Wellmark Health Plan of Iowa, and Delta Dental of Iowa are currently available in all 99 Iowa counties.

## IowaCare

IowaCare, created in 2005, is a health care program that provides limited services for adults ages 19 through 64 who have incomes below 200% FPL and are not otherwise eligible for Medicaid. IowaCare was created to provide some health care coverage to people who would otherwise have no coverage and will be terminated on December 31, 2013. Effective January 1, 2014, the 70,000 IowaCare enrollees will begin receiving health care services from the Iowa Health and Wellness Plan.

IowaCare provides the following limited benefit package:

- Inpatient & outpatient hospital services
- Doctor & Advanced Registered Nurse Practitioner services

- Limited prescription drug services
- Limited dental services
- Routine preventative medical examinations
- Smoking cessation services

IowaCare also has a limited network of providers and individuals outside of Des Moines or Iowa City frequently travel great distances for care.

## Oral Health

### Adult Oral Health

Decades of research have shown that oral health has an impact on overall physical health. Additionally, studies indicate that lower income adults and children often have more untreated oral health needs, most often due to lower access to dental care. Across the country, this lower access is often linked to low levels of participation of dentists in Medicaid. A recent study by the University of Iowa Public Policy Center found that the same is true in Iowa. This study also found that dentists in Iowa cite reasons for their low participation in Medicaid that are similar to reasons cited nationally, including low reimbursement and other payment issues, as well as challenges with patient non-compliance and broken appointments.

In a June 2013 evaluation of the IowaCare program, the University of Iowa Public Policy Center found that “the self-reported oral health of IowaCare enrollees was much lower than their overall physical health and also much lower than the self-reported oral health status of adult Medicaid enrollees”. About “34% of IowaCare enrollees reported their oral health as ‘poor’ as compared to only 13% of Medicaid enrolled adults”. Oral health problems were the number one most common chronic condition experience by IowaCare enrollees, and nearly half of IowaCare enrollees reported an unmet need for dental care in the past six months.

### Children’s Oral Health

In the 2010 Iowa Child and Family Household Health Survey, approximately 77% of parents reported their children’s oral health as “excellent” or “very good”.<sup>99</sup> For comparison, approximately 91% of parents reported their children’s physical health as “excellent” or “very good”. The results depended on the family’s poverty level, with poorer families reporting lower percentage with “excellent” or “very good” oral health.

**Table 32: Oral Health Status by Income**

Family Income	% of Families Reporting their Children’s Oral Health is “Excellent” or “Very Good”
< 134% FPL	62%
134% - 199% FPL	74%
200% or more FPL	82%

Source: Damiano, Peter C., et. al. 2012. *Oral Health in Children in Iowa: An Overview From the 2010 Iowa Child and Family Household Health Survey*. University of Iowa Public Policy Center.

More parents reported that their children lacked oral health insurance (18%) than reported that their children lacked physical health insurance (3%). Approximately 89% of children in lower income families had dental coverage. This is a result of the mandatory dental coverage in Medicaid and the Children's Health Insurance Program, called Hawk-I in Iowa. Approximately 90% of parents surveyed indicated that their children had one main place, a dental home that they went to receive dental services. Higher percentages were reported for African American children (97%) and those with dental insurance (95%).

During the previous year, 78% of children needed dental care. This is significantly higher than those reporting the need for medical care (57%). Of all children, 95% required a checkup/cleaning, 24% needed fillings, and 3% required emergency care. For children in families under 133% of the FPL, approximately 10% had an unmet dental care need, whereas only 3% of children of upper income families reported an unmet dental need. Although African American children are most likely to have dental insurance, 20% reported an unmet dental need compared to 8% of Hispanics, and 3% of white children.

Children with dental insurance were more likely to receive a dental checkup during the previous year than those who lacked dental insurance. Approximately 91% of parents reported that their child with dental insurance received a checkup while 79% of parents reported that their child lacking dental insurance received a checkup. Children with special health needs were most likely to have had a checkup (94%) and children under 4 years old were least likely to have had a checkup.

The "2010 Oral Health Survey Report Infants and Toddlers in Iowa's WIC Program" provides additional information about the oral health status of children in Iowa. This survey found that

Most of the children had Medicaid as their payment source for dental care (80.9%). Eleven percent of surveyed children had untreated tooth decay, 5.9 percent had at least one filled tooth, 15.3 percent had a history of tooth decay (filled tooth and/or decay), and 20.9 percent had demineralized enamel. Seventy-five percent of the children with untreated decay were age 3 or 4.

Two-thirds of children had never seen a dentist (67.8%). Of the children with untreated decay, 61.4% had never seen a dentist. No children younger than age one had seen a dentist, compared to 88.4% of one-year-olds and 70.1% of two-year-olds. Fifty-four percent of 3-year-olds had not seen a dentist, improving to 31.4% of 4-year-olds whose parents indicated they had never seen a dentist. Twenty-three percent of children had seen a dentist within the past 6 months and 9% between six months to a year prior. Two thirds of those children were age 3 or 4 (65.8%).<sup>100</sup>

## Medicare

In 2012, there were approximately 530,000 Iowans enrolled in Medicare. This represents 17% of the total population. (This number is higher than the CPS estimates stated previously because it is from CMS enrollment numbers, is a count of anyone ever enrolled, and includes those who are dually eligible for Medicaid and Medicare). As with the Medicaid line of business in Iowa, a relatively small percentage of enrollees are in a capitated delivery and payment system: only 13.9% of Medicare beneficiaries are enrolled in a Medicare Advantage plan (the national rate is 27.0%).

Over the past several years, Iowa's Medicare system has begun to undergo innovative change as well, with Medicare ACOs beginning to operate in the State. Many of these Medicare ACOs were first ACOs with Wellmark. Current ACOs are:

- Trinity ACO (Fort Dodge area); this is a Pioneer ACO with about 10,600 enrollees
- Alegent Health Partner, LLC (serving both Iowa and Nebraska)
- University of Iowa Affiliated Health Providers, LC (Linn, Benton, Jones, Cedar, Iowa, Johnson and Tama counties) which has approximately 18,000 enrollees
- Mercy ACO (Polk, Warrant and Dallas counties) which has 22,500 enrollees
- UnityPoint Health Partners, LC (Cedar Rapids, Waterloo, Des Moines, Davenport, Bettendorf and Muscatine counties) which has about 75,000 enrollees of which about 47,000 are Iowa residents

Under the Medicare Shared Savings Program (MSSP), there are two models of payment. The first is advance payment in which participants in the Shared Savings Program receive advance payments that are repaid from the future shared savings they earn. CMS recoups these advance payments from an ACO's shared savings. If the ACO does not generate sufficient savings to repay the advance payments as of the first settlement for the Shared Savings Program, CMS will continue to offset shared savings in subsequent performance years and any future agreement periods, or pursue recoupment where appropriate. Three types of payments available to an ACO are:

- An upfront, fixed payment: each ACO receives a fixed payment.
- An upfront, variable payment: each ACO receives a payment based on the number of its preliminarily prospectively-assigned beneficiaries.
- A monthly payment of varying amount depending on the size of the ACO: each ACO receives a monthly payment based on the number of its preliminarily prospectively-assigned beneficiaries.

In Iowa there is also a Medicare Pioneer Model, which differs from the MSSP in that in the first two performance years, the Pioneer Model tests a shared savings and shared losses payment arrangement with higher levels of reward and risk than in the Shared Savings Program. These shared savings would be determined through comparisons against an ACO's benchmark, which is based on previous CMS expenditures for the group of patients aligned to the Pioneer ACO. In year three of the program, those Pioneer ACOs that have shown savings over the first two years will be eligible to move to a population-based payment model. Population-based payment is a per-beneficiary

per month payment amount intended to replace some or all of the ACO's FFS payments with a prospective monthly payment. While the reimbursement methodology and some of the quality metrics differ across the Medicare, Wellmark and Medicaid ACOs, the fact that all of these payers are aligned, are supporting providers as they change the way that care is provided, and are holding providers more accountable for value of services will increase the likelihood of success. It is much easier for providers to transform their practices across all payer than to focus on just one. Over time, the State anticipates there will be further alignment.

## Commercial

For commercial insurance, it is notable that, in comparison to the national average, Iowa's largest carrier, Wellmark Blue Cross Blue Shield, holds an unusually high percentage of the market shares for:

- Small group: 63% vs. 50% percent nationally
- Large group: 77 % percent vs. 58% percent nationally
- Individual: 84% percent vs. 55% percent nationally<sup>101</sup>

Wellmark covers about 1.8 million Iowans and has over 1,800 employees. In 2011, Wellmark began developing ACO arrangements with three health systems. One of the first commercial ACOs in the Midwest, Wellmark embraced three main tenets as an early adopter:

1. A primary focus on quality care;
2. Use of population risk-adjustment, and
3. Presence of actionable data.

In addition to following the main components of the standardized, five-year ACO contract such as member attribution and shared savings, the Wellmark ACO utilizes online performance dashboards, based on monthly updated claims information, to inform and track quality and financial performance. As of January 2014, there will be 454,407 members enrolled in a Wellmark ACO (this includes those who are in self-funded plans). All of these members are used for setting targets. However, only the 254,000 members which are not enrolled in self-funded plans are used for the actual budgets since the self-funded plans are not part of the ACO cost savings program.

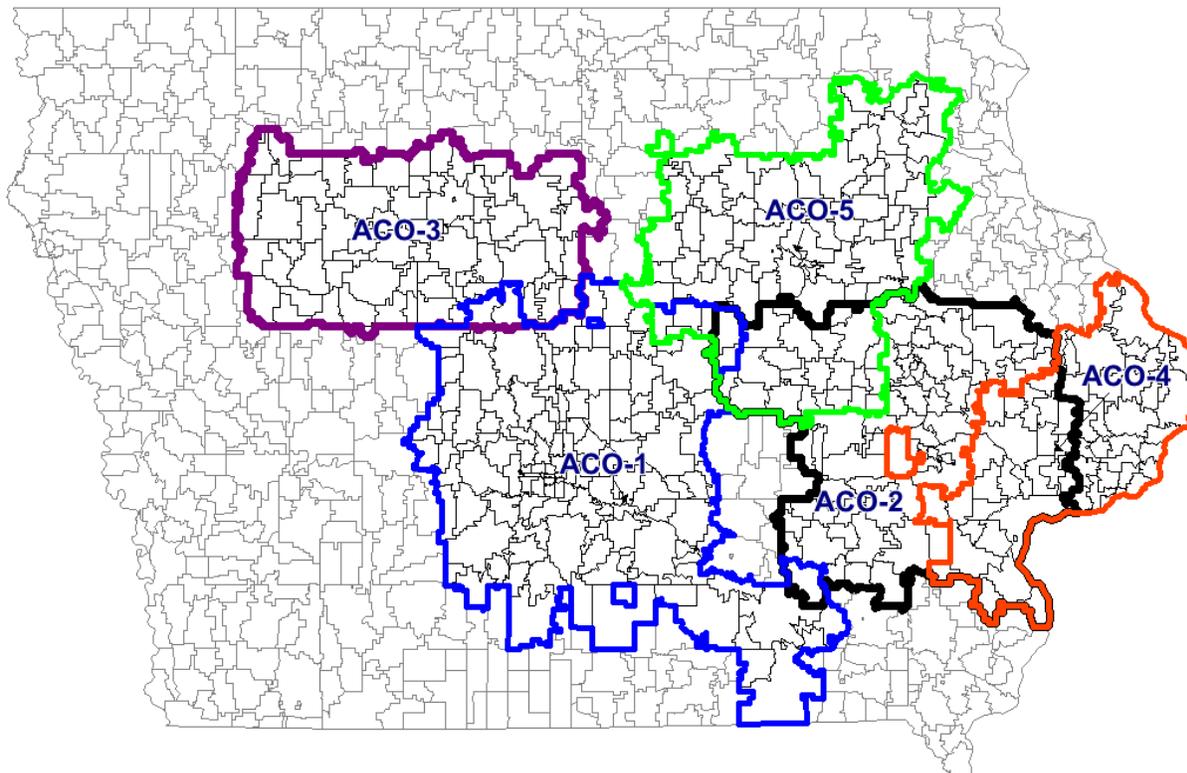
Four health systems currently participate in the Wellmark ACO. Currently:

- 64% of the counties in the state have a Wellmark ACO;
- 31% of the counties have more than one commercial ACO;
- 79% of the Medicaid population is in a county with at least one commercial ACO; and
- 85% of the projected Iowa Health and Wellness Plan population reside in a county that has at least one commercial ACO.

The State is proposing to implement Medicaid regional ACOs. As shown below, five of the six proposed regions have at least one ACO operating and three of the regions have more than one ACO.

- Region 1 – Des Moines (UnityPoint Health, Mercy Medical Center)
- Region 2 – Cedar Rapids (UnityPoint Health)
- Region 3 – Fort Dodge (UnityPoint Health)
- Region 4 – Davenport (Genesis Health Systems, UnityPoint Health)
- Region 5 – Waterloo (UnityPoint Health, Wheaton Franciscan Healthcare)

**Figure 36: Commercial ACOs – Wellmark Service Areas**



The ACOs share in savings or losses by a pre-selected percentage (50, 60 or 70) and there are financial targets that trigger shares savings payment. There are also incentive payments tied to provider performance on the VIS. Section 8 provides more detail about the seven core domains which are:

1. Member experience
2. Primary and secondary prevention
3. Tertiary prevention
4. Population health statues
5. Continuity of care
6. Chronic and follow-up care
7. Efficiency

Based on the first year of financial and quality indicators, the Iowa Health System d/b/a UnityPoint Health, Mercy Medical Center, and Genesis Health System have shown promising financial and quality improvements.<sup>102</sup>

## 8. “As Is” Current Health Care Delivery System Performance Measures and Factors Affecting Quality (Responds to the First Part of Question 7 and all of Question 9)

As can be seen in the table below, for all major indicators of system performance with the exception of the number of inpatient back surgeries per 1,000 Medicare enrollees, Iowa demonstrates higher system performance indicators than national averages. In the majority of system performance indicators, Iowa is within several percentage points of national averages but there is a large gap between Iowa's rate and the states with the best (highest or lowest depending on the measure) score. In other words, Iowa's rates are generally better than average but rarely within the top performing states.

**Table 33: Opportunities for Improvement**

Measure	Iowa	United States
<b>Potential for Improved Coordination</b>		
<b>Preventable hospitalizations per 100,000 population, 2009<sup>103</sup></b>		
Adults	1,174.9	1,395.1
Children	134.7	189.9
<b>Avoidable emergency room (ER) visits as a share of all ER visits, 2009<sup>104</sup></b>		
Total	48.2%	49.3%
Medicaid	56.0%	56.3%
Medicare	45.3%	44.9%
Private insurance	44.6%	46.2%
<b>Medication compliance: % of CVS Caremark patients with certain chronic conditions with "optimal" medication compliance, 2010<sup>105</sup></b>		
	67.0%	64.6%
<b>Medicare 30 day hospital readmissions as a % of all admissions, 2009<sup>106</sup></b>		
	14.4%	18.0%
<b>Rate of low birth weight births, 2010<sup>107</sup></b>		
	7.0%	8.1%
<b>Potentially Avoidable Costs and Overuse</b>		
<b>Emergency room visits per 1,000 population, 2010<sup>108</sup></b>		
	401.1	411.3
<b>Rates of births by Caesarean section, 2010<sup>109</sup></b>		
	30.3%	32.8%
<b>Imaging Costs, Medicare Fee for Service, 2010<sup>110</sup></b>		
Per Capita	\$186	\$286
Ratio to National Average	0.65	1.00

Measure	Iowa	United States
<b>Home Health Care Costs, Medicare Fee for Service, 2010<sup>111</sup></b>		
Per Capita	\$223	\$640
Ratio to National Average	0.35	1.00
<b>Inpatient back surgery per 1,000 Medicare enrollees, 2007<sup>112</sup></b>		
	4.9	4.5
<b>End of Life Care</b>		
<b>% of decedents spending 7 or more days in ICU/CCU in last 6 months of life, 2007<sup>113</sup></b>		
	9.1%	15.2%
<b>Inpatient spending per decedent in last 6 months of life, 2007<sup>114</sup></b>		
	\$10,637	\$14,788

Source: Analysis of data from NORC SIM TA team prepared for the *Benchmark State Profile Report for Iowa*. Specific data sources are included in the end notes.

Quality performance measures are an important component of health delivery, allowing for standard measures across payers that indicate the efficiency and effectiveness of the entire system, both providers and health plans. With the statewide Medicaid ACOS, the State intends to use this kind of information to target areas of need and develop interventions that build upon community strengths.

## Medicaid Performance

Within managed care and the MediPASS program, Iowa measures quality performance in multiple ways. Key performance measures include HEDIS measures, and Consumer Assessment of Health Plan Study (CAHPS) measures and, in partnership with the University of Iowa Public Policy Center, a number of quality performance studies and evaluation of specific initiatives have been conducted. These include evaluations of the IowaCare Program<sup>115</sup> and the MediPASS<sup>116</sup> program using CAHPS measures and supplementary questions about access to care and dental care, as well as claims and encounter data. For the Medicaid HMO currently in existence (Meridian), beginning in 2002, the DHS requires accreditation by either the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the National Committee for Quality Assurance (NCQA).

For behavioral health services, Magellan is required to maintain a comprehensive quality improvement program that includes: attaining and maintaining accreditation through a national body; evaluating the performance of clinical, preventative, and support processes; pursuing opportunities to improve programs and outcomes; tracking public input through quality assurance processes; implementing focused quality improvement studies and prevention programs; conducting satisfaction surveys; and monitoring and reporting performance indicators established in the contract<sup>117</sup>. State regulations also require an internal quality assurance system that meets the requirements of 42 CFR 434.44

For LTCSS, quality performance measures include the Balancing Incentives Payments Program (BIPP) measures discussed previously. Other performance measures include measures of quality and satisfaction within the Home and Community Based Services System, as well as administrative monitoring to ensure health and safety of enrollees. In sum, the quality monitoring meets federal and state minimum requirements but there is certainly opportunity with ACOs to closely monitor to ensure high-quality care is delivered.

## Medicare Performance

The CMS Quality Strategy pursues and aligns with the three broad aims of the National Quality Strategy. Medicare measures quality using the following general areas of focus: patient and caregiver satisfaction, care coordination and patient safety, preventive health, and health outcomes, with a specific focus on people with chronic conditions or who are at risk for chronic conditions.

Under the CMS ACO initiatives, ACOs are held accountable to quality of care using nationally recognized measures in four key domains: Patient/caregiver experience (7 measures); Care coordination/patient safety (6 measures); Preventive health (8 measures); At-risk population: Diabetes (1 measure and 1 composite consisting of five measures), Hypertension (1 measure), Ischemic Vascular Disease (2 measures), Heart Failure (1 measure), Coronary Artery Disease (1 composite consisting of 2 measures). Before an ACO can participate in sharing in any savings created, it must demonstrate that it met the quality performance standard for that year.

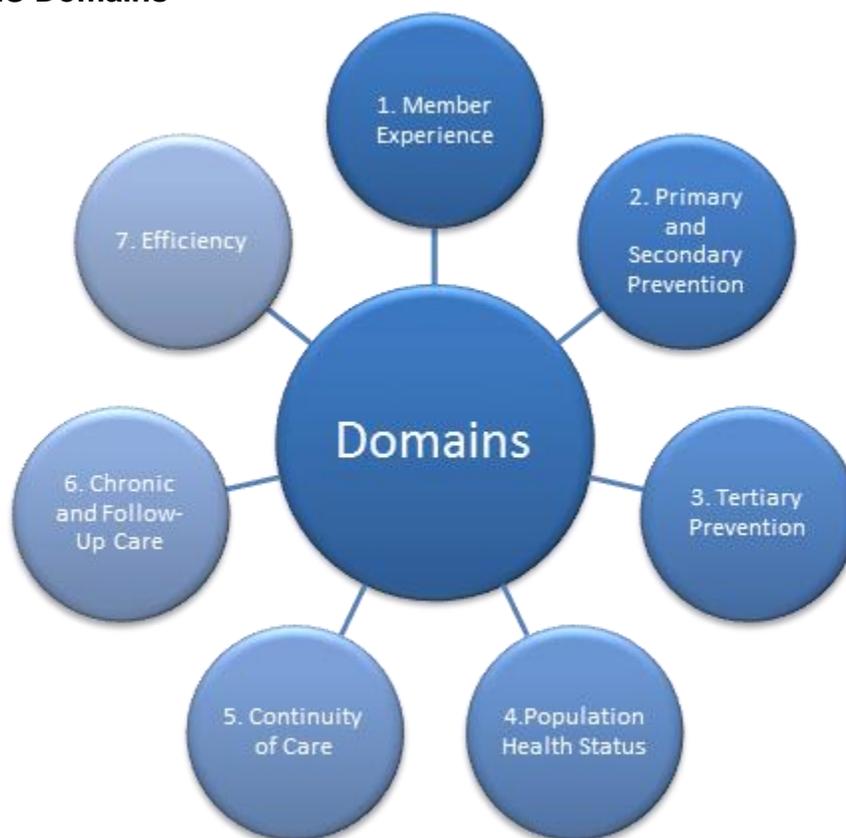
Patient satisfaction is measured using CAHPS (administered annually), and other ACO quality measures align with those used in other CMS quality programs, such as the Physician Quality Reporting System and the Electronic Health Record (EHR) Incentive Programs. The ACO quality measures also align with the National Quality Strategy and other HHS priorities, such as the Million Hearts Initiative. Medicare's quality strategy includes the utilization of Quality Improvement Organizations (QIOs) that assist Medicare beneficiaries and their caregivers in understanding and using quality measures information in their healthcare decision making process.

CMS is continuously working to refine and improve its quality strategy, the measures, and the use of the measures. For example, to develop new measures, the developers utilize the Measures Management System (MMS), which is a set of business processes and decision criteria that guide developers in the development, implementation, and maintenance of quality measures. As another example, CMS is working to review assessment approaches that could be used across post-acute settings to reduce care fragmentation and unsafe transitions, and to compare outcomes and costs for patients discharged to post-acute care, and has developed a plan to improve Medicare's payment for post-acute care services and the coordination of these services. CMS is also working to develop measures to monitor and evaluate the quality of rehabilitation services provided to Medicare beneficiaries in Inpatient Rehabilitation Facilities.

## Commercial Performance

As noted previously, the Wellmark ACOs in Iowa use the Value Index Score (VIS) to assure quality among their health plans providers. The Value Index Score is a single composite value that pulls together various domains of value into a single score that represents a comprehensive look at the practice of a PCP. Scores can be aggregated to the ACO level as well. Each domain that is part of the VIS includes well-researched measures that can be influenced by changes in provider behavior. While each domain can be viewed on its own, the VIS offers an overall score that can be used to rank provider performance and to compare a provider's score to the overall average score for the system or network, which helps to pinpoint areas that may require more scrutiny for performance improvement. Of the seven domains, six are driven from claims data, meaning that no special collection or processing is needed in addition to claims filing. These domains are depicted below.

**Figure 37: VIS Domains**



### Domain One: Member Experience

Recent studies have shown that patient experience has an impact on clinical outcomes. As a result, payers are looking closely at patient experience as a value-based purchasing (VBP) metric. For example, CMS is now using patient experience as measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for Medicare VBP. This marks the movement towards new and

growing financial incentives to strengthen patient experiences with care. In order to account for this emerging focus, there is a domain that evaluates patient perception of care within the Value Index. This domain, the only one that does not rely on claims data, has four core measures drawn from the “How’s Your Health” survey developed by John Wasson, MD Professor of Community and Family Medicine, and Medicine at Dartmouth Medical School. The member experience domain incorporates:

- patient confidence
- continuity of care
- office efficiency
- access to care

The VIS is an important step in examining the overall value of care provided to a provider's patient population. It allows for payers and providers to identify areas where attention and interventions may be necessary. These interventions include new delivery system approaches such as medical homes and ACOs.

The VIS can be used to compare overall performance relative to the cost of care. For example, PCPs can be ranked into deciles based on the total cost of care for their attributed population as a percent related to expected or average cost on a risk adjusted basis. The VIS is then plotted for each of the deciles. Generally, the better VIS scores (above expected) correlate with better total cost of care (below expected).

## **Domain Two: Primary and Secondary Prevention**

This domain measures the provider’s performance on screening services designed for early detection or prevention of disease. These measures are drawn from the National Committee for Quality Assurance’s (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS), a tool used by more than 90% of America’s health plans to measure performance. The domain includes scores for:

- percent of the provider’s pediatric well-visits for children 30 days to 15 months, and 3 years to 6 years
- percent of the provider’s mammogram screening to applicable patient populations
- percent of the provider’s colorectal cancer screening to eligible patient population

## **Domain Three: Tertiary Prevention**

In addition to primary and secondary prevention to help keep the population healthy, the VIS has a tertiary prevention domain that evaluates the effectiveness of a provider in addressing “sick” care. This domain includes:

- percent difference between the expected number of hospital admissions that are potentially preventable and the actual rate of the provider’s population
- percent difference between the expected number of hospital emergency room visits that are potentially preventable and the rate of the provider’s population

## **Domain Four: Population Health Status**

One measure for determining providers' ability to deliver quality care is their ability to manage the health status of their patient panel from one time period to another. This domain uses a risk-adjusted assessment of the percent difference between the expected rate of disease progression and the actual rate of the disease progression in the provider's patient panel. The population health status domain uses two metrics of disease progression:

- Change in the number of chronic conditions
- Change in the severity within the chronic conditions

## **Domain Five: Continuity of Care**

This domain measures the concentration and continuity of physician visits. The continuity of care domain is associated with a number of positive outcomes, such as lower rates of hospitalization and readmissions, more efficient medical care, and higher patient satisfaction. It includes:

- percent difference between the expected continuity of care score for providers serving similar populations and the actual score for the provider's panel
- percent of the provider's panel visiting a primary care provider (pcp)
- percent of provider's panel that visit a physician during evaluation year

## **Domain Six: Chronic and Follow-up Care**

For members of the population who have chronic conditions, the VIS measures the processes and impact of chronic and follow-up care. The domain includes:

- percent difference between the number of expected hospital readmissions that are potentially preventable and the provider's actual number of potentially preventable readmissions
- percent of the provider's panel that visited a physician office within 30 days post-discharge
- percent of the provider's panel with chronic disease that have three or more physician visits

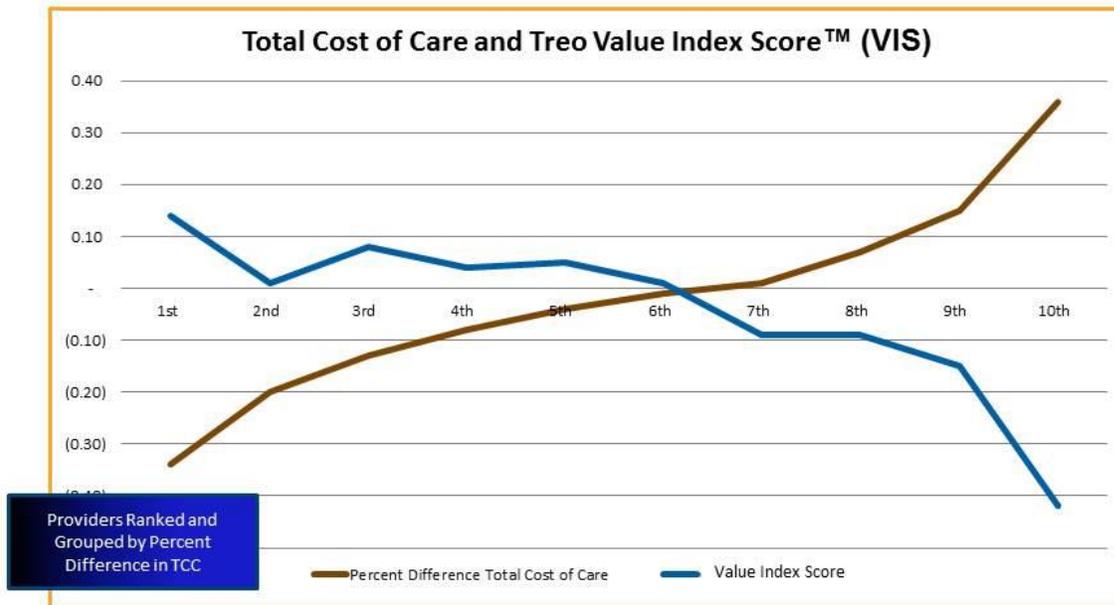
## **Domain Seven: Efficiency**

The efficiency domain examines the risk-adjusted rate of prescribing generic medications and the appropriate use of outpatient services for a physician's panel. The analysis of outpatient services examines potentially preventable ancillary services, such as high cost imaging, ordered by primary care physicians or specialists that may not typically provide useful information for diagnosis and treatment. The domain examines:

- percent difference between a physician's risk-adjusted performance on potentially preventable services and the expected rate for a comparable population
- percent difference between a physician's risk-adjusted rate of prescribing generic drugs and the expected rate for a comparable population

Figure 38:

## Total Cost of Care: System Efficiency



Wellmark also collects data sets corresponding to HEDIS. Wellmark randomly selects patient records and indicates whether certain tests or screenings were done. These indicators are taken from the NCQA and include the most prevalent health issues including:

- Adolescent Immunizations
- Childhood Immunizations
- Human Papillomavirus Vaccine for Adolescent Females
- Prenatal and Postpartum Care Visits
- Comprehensive Diabetes Care
- Blood Pressure Control
- Cholesterol Management for patients with cardiovascular conditions
- Adult BMI Assessment
- Weight Assessment, Nutritional Counseling, and Physical
- Activity Counseling
- Colorectal Cancer Screening

Since 2001, Wellmark has been awarded Excellent status based on an annual assessment of HEDIS clinical measures and annual CAHPS survey results.

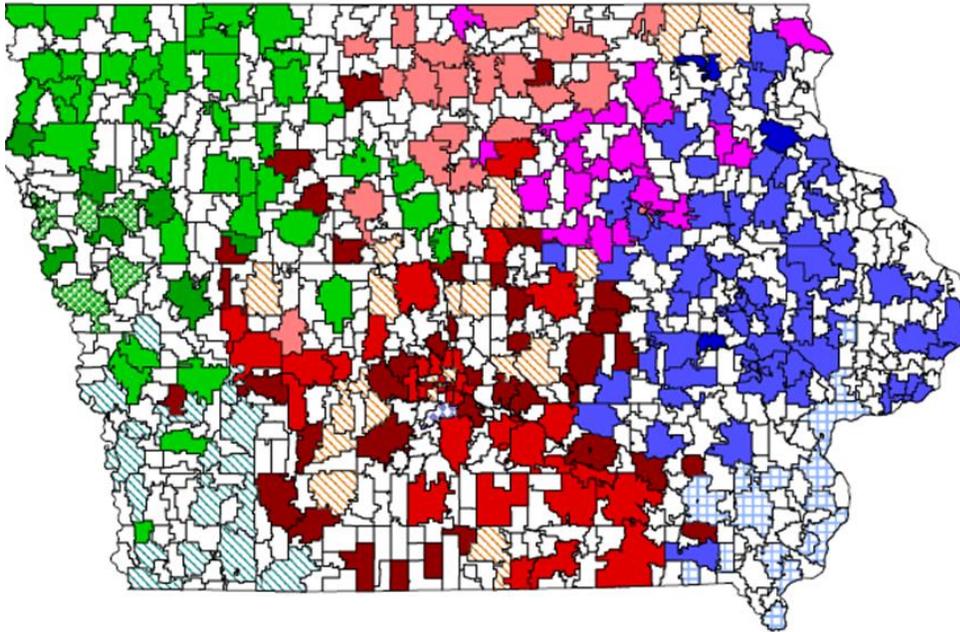
## 9. Analysis of Medicaid Practice Patterns

The State has been committed to using data to drive decisions about regions, priorities, payment approaches and contracting requirements. To ensure the development of a "data-drive SHIP" SIM monies have been used to support significant analysis of Medicaid claims data. The information below has been developed to understand practice patterns and to make program design decisions that address any identified areas of opportunity for savings, improved care and, ultimately, improved health of Iowans.

### Medical Neighborhoods and Regions

One of the State's goals for the innovation model design was to use data to make decisions about the regional approach to developing the ACOs and to use the analysis to identify opportunities for cost savings and quality improvement. One of the first steps in developing the regions was to identify medical neighborhoods that exist currently, by using algorithms that account for shared referral patterns between PCPs to shared specialists. The strength of these relationships is determined by the number of referrals and distinct specialties shared. These relationships, in turn, uncover existing medical neighborhoods, which then uncover naturally occurring regions. It is important to note that these medical neighborhoods are reflective of the entire Medicaid population except for those receiving LTCSS, those who are dually eligible, are enrolled in an HMO or have eligibility through the Iowa Family Planning Network or Iowa Care. Those with presumptive eligibility are also excluded. As a result, the medical neighborhoods reflect these relationships in the aggregate, but may not exactly reflect the referral patterns for certain sub-populations. One example of this is children with complex health care needs, primarily because there are essentially two medical neighborhoods: Des Moines and Iowa City. These relationships and neighborhoods are illustrated in the maps below.

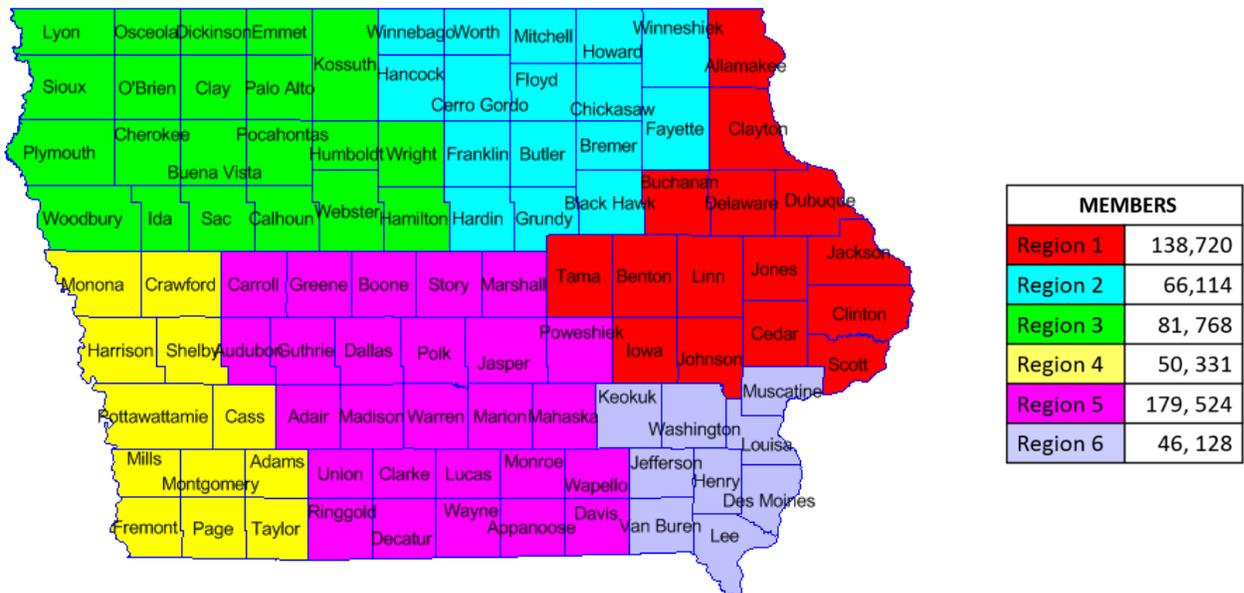
**Figure 39: IME Medical Neighborhoods**



Medical neighborhoods were developed using algorithms that account for shared referral patterns between PCPs to shared specialists. Analysis of CY 2012 Iowa Medicaid data. LTC (institutional), Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare populations were excluded from the analysis.

Final regions were derived by examining the medical neighborhoods at the zip code level and drawing geographic lines at the county level. Using the referral patterns as a guide, medical neighborhoods were identified and placed into six regions: northeast (1), north central (2), northwest (3), southeast (4), south central (5), and southwest (6).<sup>118</sup>

**Figure 40: Proposed Regions**



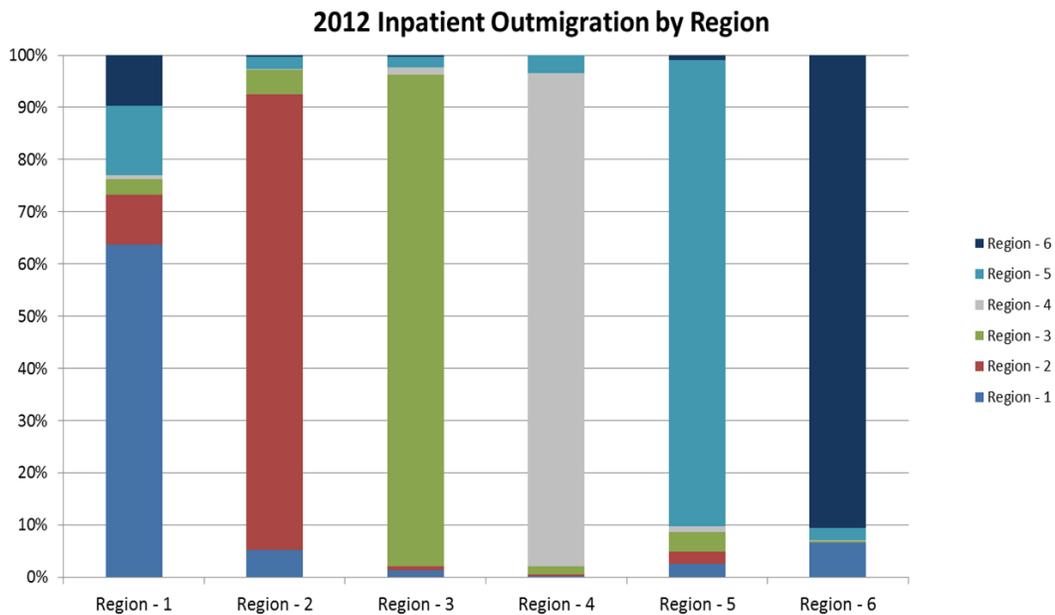
Note: Regions defined by observing medical neighborhoods at the zip code level and drawing hard geographic lines at the county level. Analysis of CY 2012 Iowa Medicaid data. LTC (institutional), Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare populations have been excluded from the analysis

## Migration of Dollars Across Regions

The analysis also considered the value of inpatient and outpatient dollars that were spent in a region other than the one in which the member resided. As demonstrated below, except for Region 1, the vast majority (>85%) of inpatient expense remained within the region (e.g. beneficiaries sought services from facilities within their region). This analysis further validates the existence of the regional medical ecosystems that have been identified through the claims analysis process.

**Figure 41: Across Regional Movement for Inpatient (IP) Services**

**% of dollars associated with in-state movement of members seeking IP services to other regions.**

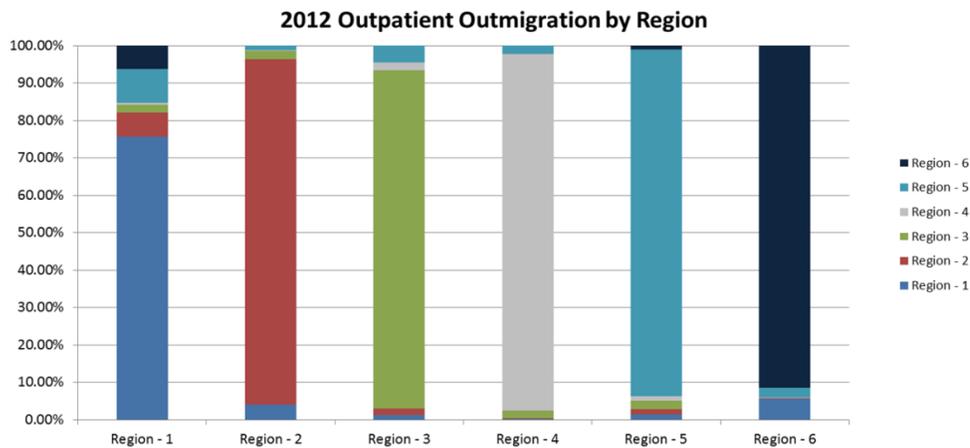


Analysis of CY 2012 Iowa Medicaid data. The following populations were excluded: LTC (institutional), Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare.

The patterns are similar for migration of outpatient dollars to regions that do not include the beneficiaries' zip codes.

## Figure 42: Across Regional Movement for Outpatient (OP) Services

% of dollars associated with in-state movement of members seeking OP services to other regions.



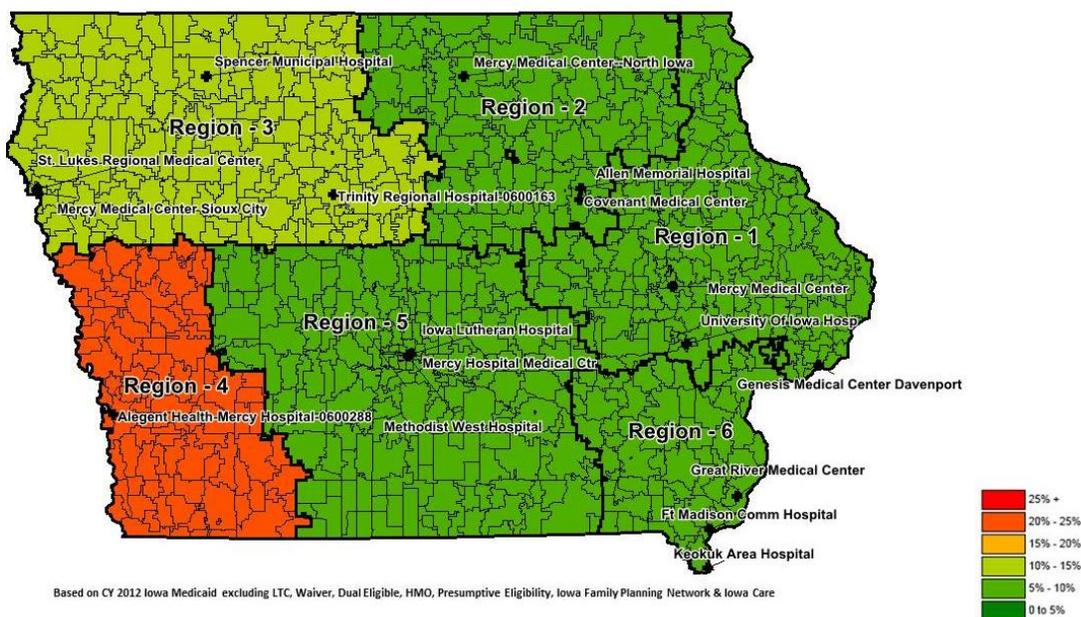
Analysis of CY 2012 Iowa Medicaid data. The following populations were excluded: LTC, Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare.

## Migration of Dollars Out of State

The State also conducted analysis to assess the extent to which Medicaid enrollees in each of the six medical neighborhoods seek care outside of Iowa and what percentage of Medicaid reimbursements are going to out-of-state providers.

## Figure 43: Out-of-State Dollars Paid by Region

% Total Dollars Paid Outside the State



Based on CY 2012 Iowa Medicaid excluding LTC, Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network & Iowa Care

Relative to the other regions, Regions 3 and 4 have high percentages of inpatient dollars leaving the State. Over 50% of the total dollar outmigration from these regions was paid to three hospitals: Children's Memorial in Omaha, Bergan Mercy in Omaha, and Nebraska Health Systems. Regarding outpatient dollars, over \$11 million are leaving the state, with therapy (including speech, physical and occupational therapy) being the highest utilized service going over the border. The State is paying out-of-state therapy service providers at a rate that is 47% higher than the in-state average rate.

Understanding this outmigration will help IME evaluate approaches in care management proposed by prospective ACOs. It will also provide IME with insight on potential contracting opportunities to improve unit pricing for these services.

## **10. Goals and Strategies for the Delivery System, Payment Structure and Quality Improvement: "To Be State"** (Responds to the Second Part of Questions 4, 6 and 7)

This section of the SHIP provides an overview and details about the envisioned "To Be" state.

The overall goals associated with Iowa's transformed healthcare system are to:

1. Achieve the triple aim: reduce the per capita cost of health care, improve the health of populations, and improve the patient experience of care (including quality and satisfaction)
2. Create a system that supports and encourages Iowans to participate in their own care
3. Encourage and support stakeholder participation in the process to transform Iowa's health care system into one that achieves the triple aim and supports Iowans in participating in their own care and in achieving improved health.

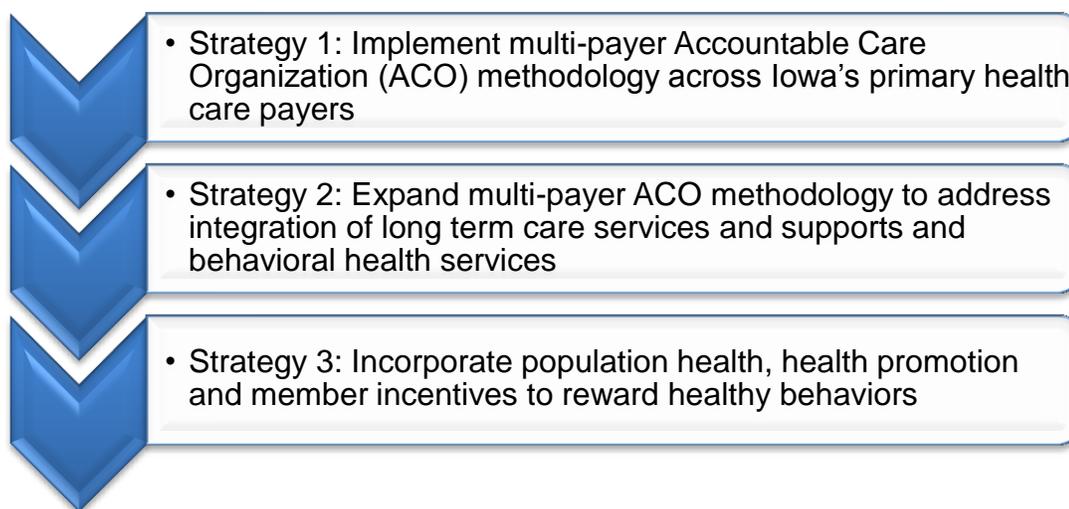
The new, transformed health care system will be a **person-centered, value-based delivery system** that makes Iowans healthier, and supports Iowans in actively participating in their care and the maintenance and improvement of their health. As part of the transformation, consistent and transparent standards and measures will be adopted that allow for demonstration of these improvements and the impacts of these improvements on Iowans' health.

The transformed system will have **dedicated and consistent leadership** within all sectors including public purchasers, private purchasers, providers, consumers, trade groups and associations, public health and other government entities. The system will embody collaboration and open communication between providers, the ACOs, the state, payers, and people receiving services. Both collaboration and open communication will be required in contracts, expected in all service delivery, measured using a standard set of measures, and rewarded. The new system will have clarity in accountability, and alignment in measures and analytics through the implementation of a standard set of measures that will be used by providers, ACOs, the state and other payers to measure

and reward progress toward the articulated goals. The new system will have transparency in data, dependable and secure connectivity with patient access to data, choices and rights.

In the original grant application for the SIM project, the State described three strategies to transform the system, and to meet the goals of improved quality and health, and lower costs. Through the stakeholder engagement process, the research process, the data analysis processes, and the state's strategic efforts, these strategies have been refined and more explicitly articulated. The strategies are as follows:

**Figure 44: SIM Strategies**



As described previously, the Iowa Health and Wellness Plan is expediting the implementation (albeit for a limited population) of strategies 1 and 3. Ultimately the model will be expanded to all Medicaid enrollees though, depending on the experience of the Iowa Health and Wellness Plan, the State may consider an interim step between the program for only the expansion population and the larger statewide initiative for all Medicaid enrollees.

## **Iowa Health and Wellness Plan**

A significant innovation in Iowa is the development and implementation of the Iowa Health and Wellness Plan. Enrolling these individuals in an ACO is Phase I of the transition to ACOs; the proposed SIM model design will build upon the Iowa Health and Wellness Plan by incorporating and building upon the ACO structure, supporting medical homes and encouraging individuals to be active participants in staying, or becoming, healthy. Although only serving a sub-set of Iowa Medicaid enrollees, the implementation of the Iowa Health and Wellness Plan will provide valuable lessons learned which will be incorporated into the larger program that will serve all Medicaid enrollees.

In May 2013, the Iowa Legislature passed the Iowa Health and Wellness Plan and CMS approved the 1115 demonstration waiver application in December 2013. The Iowa Health and Wellness Plan will implement three options that offer coverage to adults ages 19 through 64 who are not eligible for Medicaid under any other eligibility category and whose incomes do not exceed 133% of the Federal Poverty Level (FPL). The three options are:

1. The Iowa Health and Wellness Plan for eligible individuals with income up to and including 100% of the FPL and medically frail eligible individuals with income up to and including 133% of the FPL;
2. The Marketplace Choice Plan for non-medically frail individuals with income of 101% of the FPL up to and including 133% of the FPL by offering premium assistance for eligible individuals to enroll in Qualified Health Plans (QHPs) through the health insurance marketplace (Marketplace); and
3. Premium assistance for individuals with income up to and including 133% of the FPL who have access to cost-effective employer sponsored insurance (ESI) coverage under Iowa's Health Insurance Premium Payment (HIPPP) Program.

### **Iowa Health and Wellness Plan**

The Iowa Health and Wellness Plan uses delivery system innovation, care management, care coordination and quality approaches to realign the delivery system to focus on value, quality, and coordination of care. The Iowa Health and Wellness Plan promotes coordinated care through primary care physician coordination, managed care, and by building upon the anticipated work of the SIM ACOs. The Wellness Plan model will be phased in over time, beginning in 2014. The model will vary by geographic region and will depend on the delivery system readiness for ACOs and/or managed care. However, at a minimum, all members will have access to primary care that provides referrals and care coordination and focuses on quality outcomes.

Over the course of the next several years, and as ACO development increases across Iowa, more Iowa Health and Wellness Plan members will be covered by primary care physicians who are associated with ACOs. The Iowa Health and Wellness Plan, by including ACOs where they are available, seeks to support the development of ACOs across the State in concert with the State Innovation Model goals. Participating ACOs are expected to provide care coordination and management for enrollees. As with standard ACO contracts, ACOs will be held accountable for quality and cost outcomes for their assigned patient populations, and will be eligible for shared savings incentives if performance outcomes are met. ACOs are expected to achieve such savings through member outreach and engagement in preventive health, care coordination, and the use of medical homes.

The Iowa Health and Wellness Plan will provide a comprehensive commercial-like benefit plan that ensures provision of the Essential Health Benefits (EHB) and is indexed to the State Employee Plan benefits with supplemental dental benefits. Behavioral health and dental benefits will be provided as carved out benefits on a contracted basis. It also contains a unique incentive program that is intended to improve

the use of preventive services and other healthy behaviors through the elimination of monthly financial contributions for those who complete preventive health service requirements. Members with income exceeding 50% FPL will make small monthly contributions for enrollment (members cannot be removed from the program for failure to pay). For the first year of enrollment in the Iowa Health and Wellness Plan, all monthly financial contributions are waived. If members complete key health improvement behaviors in their first 12 months of enrollment, the required financial contributions are waived again for the next 12-month enrollment period. The required financial contributions are the only cost sharing for Iowa Health and Wellness Plan members other than copayments for non-emergency use of the emergency department, which apply to all members regardless of income level but are also waived in the initial demonstration year. Key health improvement behaviors may include items such as completion of preventive health care and health assessments, and such targeted behaviors will be defined by Iowa for each coverage year. Members who continue to complete health improvement behaviors in each 12-month period of enrollment will never be subject to the required monthly financial contribution. In addition, Iowa Health and Wellness Plan members will be eligible for additional incentive payments to be paid into a Health Responsibility Account (HRA) for completion of physicals, preventive services and risk assessments. The HRA account will accrue incentive payments earned by the individual. These accounts are designed to encourage completion of physicals, preventive services, and risk assessments, and will function like a debit card which can be used for health related items such as over the counter medications, gym memberships, family fitness activities, as well as gas cards. The State is exploring incentive program features as part of its SHIP and will build off the successes and lessons learned from the Iowa Health and Wellness Plan in developing a member engagement/incentive program for all Medicaid members.

Providers in the Iowa Health and Wellness Plan will be reimbursed FFS for the services provided. Primary care providers will also be paid a PMPM rate (currently anticipated to be \$4.00) for each Iowa Health and Wellness Plan member assigned to them. Primary care providers will have an opportunity to earn additional incentive payments, including a \$10.00 per member per year (PMPY) Wellness Exam Incentive and up to a \$4.00 PMPM Performance Bonus for performance on VIS measure (the system Wellmark uses).

### **Marketplace Choice Plan**

Individuals who qualify for the Marketplace Choice Plan and those who qualify for premium assistance will follow the delivery system in place for the payer and plan in which the member is enrolled. Member premiums and financial incentives are also components of the Marketplace Choice Plan. The insurance companies in the marketplace are also focusing efforts on developing medical homes and exploring opportunities for greater accountability of providers and members.

## ACO Model Specifications

### Contracting and Regions Overview

The ACO model provides an opportunity to transform Iowa Medicaid into a patient-centered system that provides better coordinated and integrated care, improves the patient experience of care, achieves better health outcomes, aligns the Medicaid program with the quality metrics and accountability requirements in Medicare and Wellmark ACOs, and reduces cost. The State envisions a model that will require partners to be true integrated care organization capable of providing the full array of services. These ACOs will not be the traditional, medical-model ACO.

All of the workgroups discussed the approach to contracting and procurement for the ACOs. From these conversations and discussions, as well as research on approaches taken in other states, the State intends to develop the model and accompanying contracts with the ACOs in the following ways.

As noted previously, the ACO model will be implemented in phases.

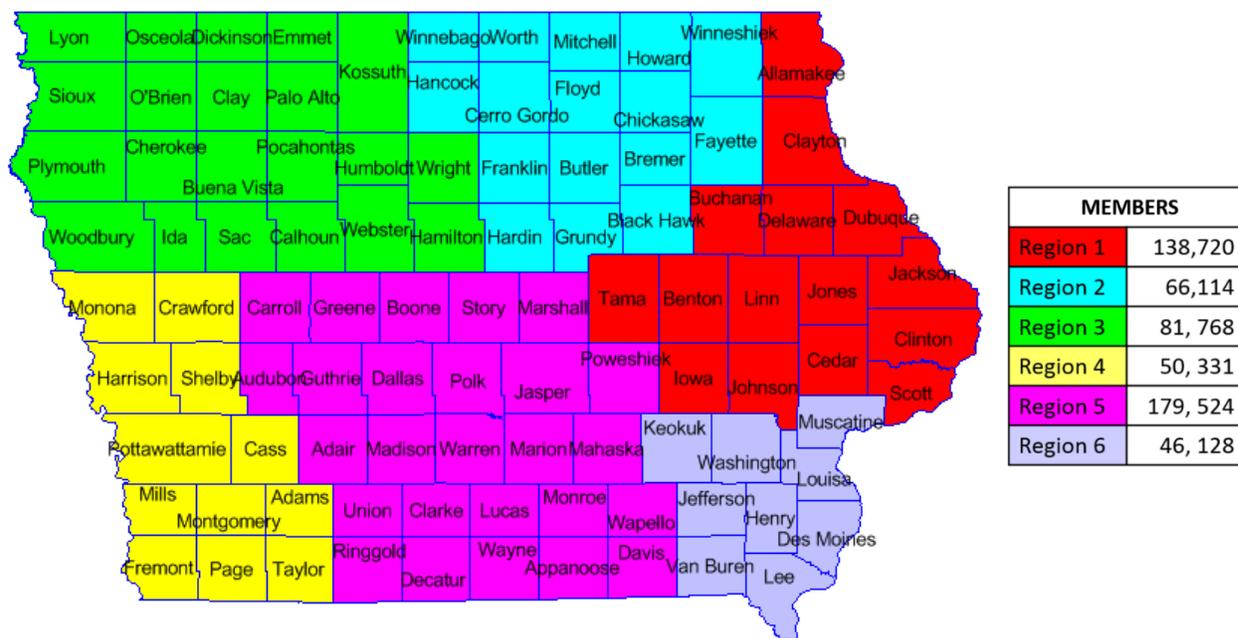
### Regional Approach to ACOs

The State will use a competitive procurement process to award ACOs based on geographic regions, using the analyses described above on existing patterns, relationships, and medical neighborhoods. The State is interested in having a collaborative approach to the contracting process and has already met with ACOs currently operating as well as entities such as the Iowa Primary Care Association. To achieve this collaborative approach, the State is considering issuing a Request for Information prior to issuing the formal Request for Proposals and finalizing the contract. Many other states take this approach.

The ACO model provides an opportunity to provide better coordination of care, and to encourage and require enhanced accountability at all levels. Regionally-based ACO models provide even more opportunities in these areas because they are more attuned and responsive to local needs, existing community entities and partnerships, and gaps in care. The ACOs will be regionally-based, with full coverage by at least one ACO in every part of the state, to ensure that the entire state (including rural areas) receives the benefits of being part of an ACO. Iowa is a very locally-controlled state, with 99 counties and 101 local public health departments. Additionally, the state varies from region to region in terms of the demographics of Iowans, and the existing health care systems, structures, organizations, and unmet needs. Regionally-based ACOs will be more attentive and responsive to these needs, and will be more aware of local resources that will be integral parts of effective care coordination. The ACO regions will be based on naturally-occurring practice and referral patterns, using existing claims data. ACO regions will be large enough to enable an ACO to have a significant volume of enrollees to have financial capacity to manage risk and to develop the infrastructure necessary to coordinate care, but small enough to allow for local approaches to care.

As described in earlier sections, preliminary data analyses suggest the existence of six naturally-occurring regions (see map below).<sup>119</sup> The regions were constructed by examining practice and referral patterns and noting where there were some natural concentrations of activity. For example, PCPs who practice in the nine southeastern counties of Iowa tend to have the same core set of referral patterns. These providers and these patients make up a naturally-occurring region. Rather than breaking up that region, it makes most sense to utilize and leverage that natural pattern. The data examined by Treo Solutions included a look at utilization and referral patterns for all Medicaid clients across the state, as well as examinations of subsets of clients, such as children, adolescents, older adults, and people with serious mental illness to see if different regions would emerge using only those data. The regions did not differ substantially when the analysis was isolated to these subpopulations.

**Figure 45: Proposed Regions**



Note: Regions defined by observing medical neighborhoods at the zip code level and drawing hard geographic lines at the county level. Analysis of CY 2012 Iowa Medicaid data. LTC (institutional), Waiver, Dual Eligible, HMO, Presumptive Eligibility, Iowa Family Planning Network and IowaCare populations have been excluded from the analysis.

### Contracting Approach to ACOs

The State does not intend to dictate what type of entity can be an ACO, nor will the State limit the opportunity to entities that are already operating as ACOs. The State will contract with the entities that submit the best proposal for its region and can demonstrate the financial, organizational and clinical capacity to provide high-quality, coordinated care while reducing costs. The State will contract with ACOs that demonstrate a culture that encourages innovation and competition, and a commitment to using innovative strategies designed to engage the Medicaid population. This might be an existing ACO, a managed care plan, a new partnership, or a safety net provider

based ACO. To begin, starting January 1, 2014, when some Iowa Health and Wellness Plan members will be enrolled in the ACOs, the State may elect to contract only with currently operating ACOs due to the compressed implementation timeline. More ACOs can be added as they become operational.

### **ACO Provider Relationships**

Throughout Iowa, there are regional and county strengths and the ACOs will be encouraged to capitalize on those strengths in developing relationships with providers and social support organizations. The culture in Iowa is strongly rooted in the communities and the 99 counties. The approach to health care and the ACO model will adapt to those unique strengths and develop an approach to supporting and growing in areas of weakness and need. The State will set a clear expectation in the ACO contracts that ACOs should partner with community-based existing providers of quality services to ensure that the individuals they serve have access to the providers they need and who provide services they currently utilize and value, including existing Integrated Health Homes, other behavioral health providers (including both mental health and substance use providers), and providers of long term supports and services (including nursing facilities, other facility-based care, and home and community based providers). In order to be successful the ACOs will also need to partner with public health, particularly to support health promotion efforts.

As ACOs become accountable for costs and quality related to long term care supports and supports, they will be working to coordinate care across these systems, which will require innovation, collaboration, and close coordination with a variety of providers around a variety of services and supports. While the state will not dictate with whom ACOs must have relationships and coordinate care, the state does expect ACOs to leverage and utilize the strengths within the existing system, and to work to reduce duplication of services, reduce gaps in services, and coordinate transitions in care. Included in this coordination will be coordination of medications across systems. Nationally, a number of innovative and effective strategies for coordination of medications across systems are emerging, including collaborative drug therapy management (CDTM) programs, which establish formal partnerships between pharmacists and physicians and allow the pharmacist to play an increased role in coordination of medications. ACOs will be encouraged to explore strategies like CDTM to help improve patient satisfaction and patient outcomes, while reducing cost by eliminating duplicative or unnecessary medications and other services.

The State will not specify in its ACO contracts specific groups or entities with whom the ACO should contract to provide services and coordination activities. Rather, the ACO will be permitted and encouraged to partner with quality providers and community organizations that will support the ACO in enhancing care coordination, reducing costs, ensuring access and changing the overall health care delivery system to one that is focused on outcomes.

## **Ensuring Accountability and Alignment with Other Payers**

To hold ACOs accountable for quality of care, patient experience of care, health outcomes, and cost, a core set of measurements will be implemented across all ACOs in Iowa. The State will encourage all ACOs to adopt and use a core set of measures. This will ensure that measures across all payers in Iowa are aligned to the degree possible and that practice change, as driven by performance, occurs across all payers. Specifically, the State will use the VIS being used by Wellmark and within the new Iowa Health and Wellness Plan structure. This approach was discussed during the workgroup meetings, providers are familiar with the VIS measures, which measure progress toward the outcomes and goals that have been identified as part of the SHIP. Also, because Wellmark is the biggest payer in the state of Iowa, it will be beneficial and efficient to use the systems that they have in place to measure performance. Using the same measures will allow for a more accurate assessment of where the state stands meeting the goals of the SHIP. This overall alignment will support providers in that they will have a "critical mass" of patients for whom they are being held accountable.

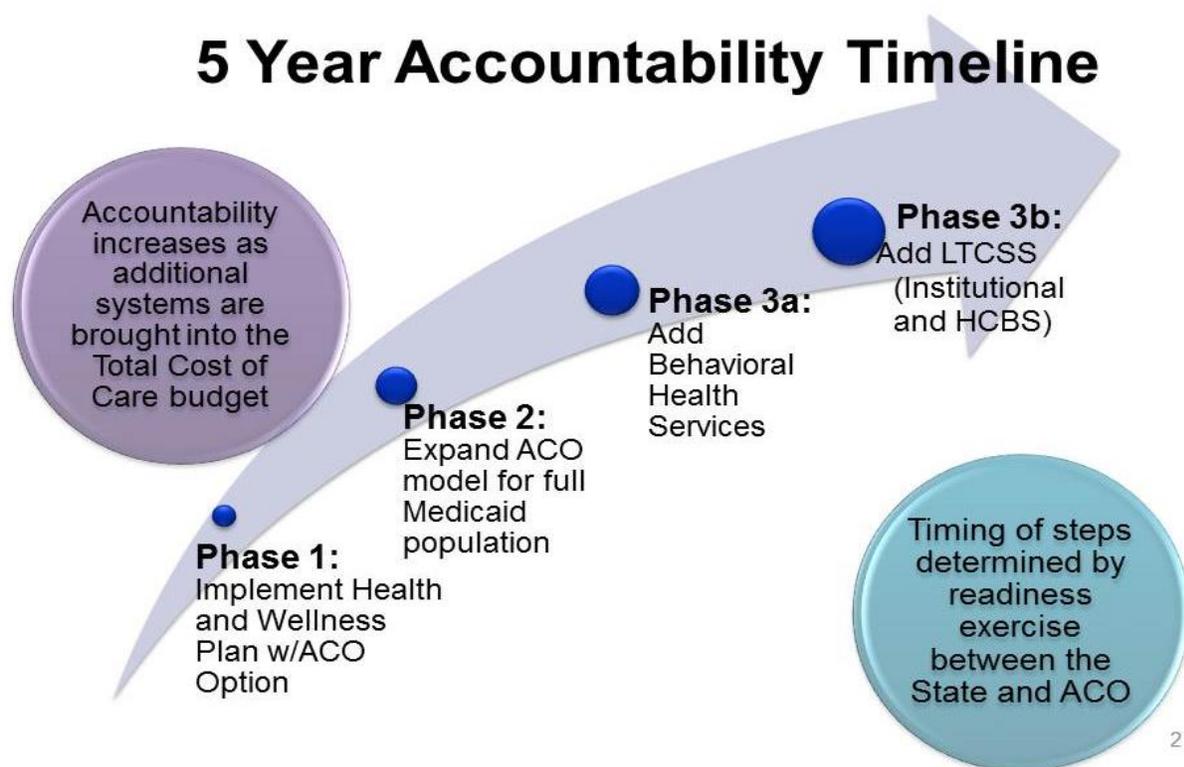
## **LTCSS and BH Measures and Accountability**

The State plans to add to the VIS additional measures that are of particular relevance to the SIM goals, and that are priorities for the Center for Medicare and Medicaid Innovation (CMMI). To support integration of behavioral health and LTCSS and recognizing that Medicaid enrollees have greater need for coordination of these services, in phases, the core set of measures will be augmented to include measures related to behavioral health and LTCSS. Behavioral health measures will include measures of members' access to and the quality of behavioral health care, as well as measures of the degree to which these services are coordinated and integrated with physical health services. Behavioral health measures will also focus on recovery and build off those articulated by the Mental Health and Disability Redesign Outcomes workgroup. Details about these measures are provided in Section XXX and in the Self-Evaluation Plan.

For LTCSS, measures will focus on the quality of these services, access to services, and the degree to which these services are coordinated and integrated with acute care services and behavioral health services. Potential measures related to long term care supports and services may be increased use of home and community based services as appropriate, and the degree to which care plans for individuals include both acute care and long term care services and supports.

ACOs will not be held accountable for costs associated with behavioral health and LTCSS in the first year, but this accountability will be added in the second or third year as ACOs become more experienced at coordinating these services. The proposed phases below are conceptual and may be refined by , for example, establishing intermediate steps between phases Figure 46 depicts one approach to increasing accountability over time.

Figure 46: Phases of Accountability



### Measures for Pediatric Populations

To ensure the focus is not solely on those individuals with high costs and high needs, the State will also either include in the VIS measures or create additional stand-alone measures that focus on ensuring the needs of children are met which will result in longer-term savings. The specific measures have not yet been determined but the State has been meeting regularly with interested stakeholders and advocates who have already proposed measures that fit into the seven VIS domains. Table xxx identifies these measures. The State will continue to work with them to adopt measures that are low cost and high impact.

### Accountability for Social Determinants of Health

Most of health is not related to the act of providing health care. Rather, access to social and economic opportunities; the resources and supports available in people's homes, neighborhoods, and communities; the quality of the schools; the safety of workplaces; the cleanliness of the water, food, and air; and the nature of social interactions and relationships have a tremendous impact on health status. Healthy People 2020, the World Health Organization, and other U.S. health initiatives such as the National Partnership for Action to End Health Disparities and the National Prevention and Health Promotion Strategy are all highlighting the importance of addressing these social determinants of health.

The State understands that true improvements in the health status of Iowans and meeting the Governor's objective to make Iowa the healthiest state will require a shift in focus. Specifically, Iowa is interested in exploring ways to hold the ACOs accountable for these non-health care factors. The need to do so was highlighted in every workgroup. As part of the refinement of the design the State will be meeting with stakeholders, providers, ACOs, and researchers to consider measures and methodologies that can support accountability in these areas.

## **Future Delivery System Payment Methods**

The State will hold the ACOs accountable to a Total Cost of Care (TCOC) calculation that is the cornerstone to any shared savings methodology. These methodologies will be risk adjusted, adjusted for healthcare cost trends, and transparent in calculation with sufficient analytics and reporting to support ACOs. The State will also explore the possibility of using social determinates of health in the risk adjustment calculation (for example homelessness status or formerly incarcerated status) as these are strong predictors of the rate of utilization of health care services and the chronicity of the individual.

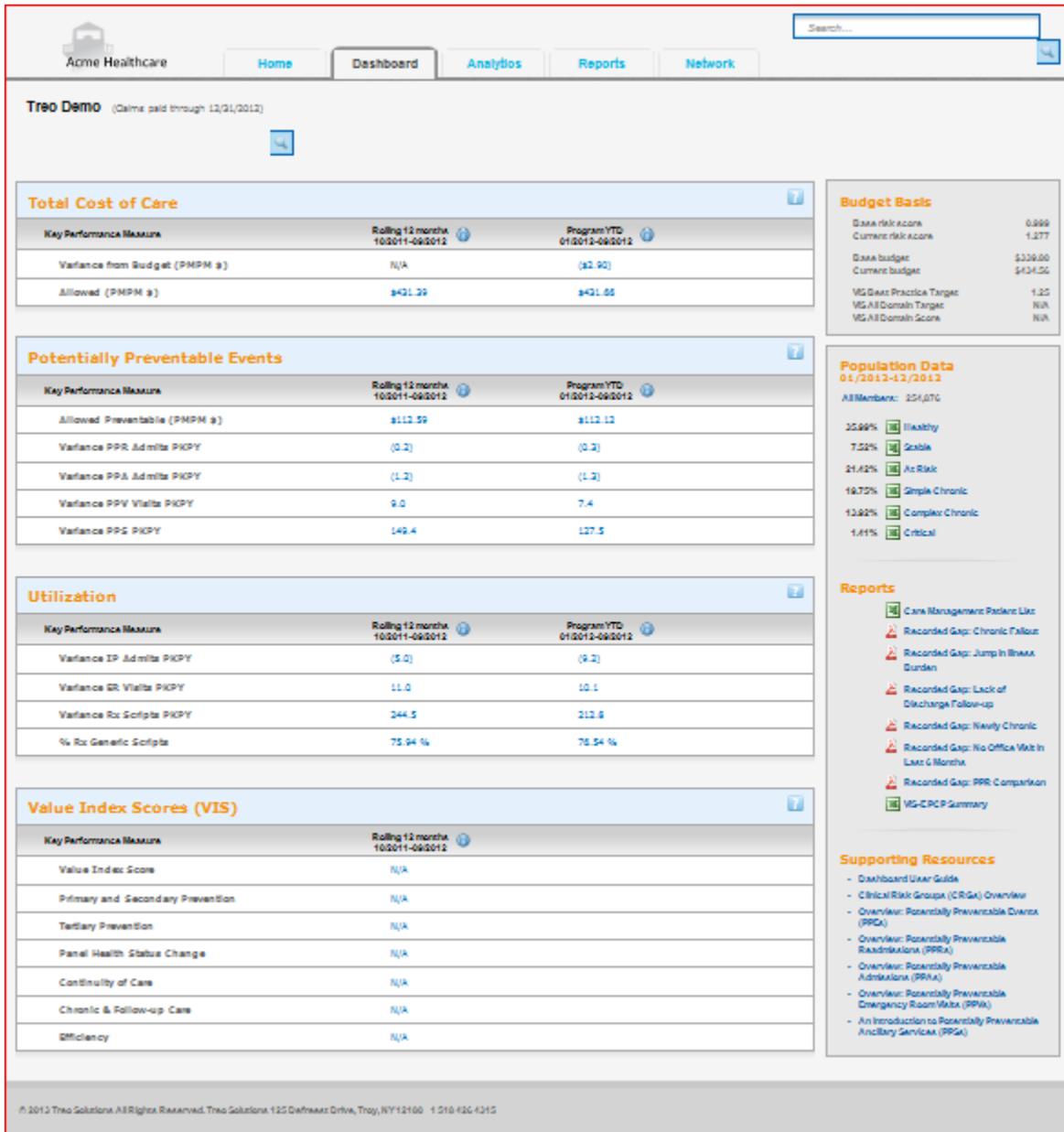
The implementation of new payment methods will be phased in over time. In Phase I, the reimbursement method for the Iowa Health and Wellness Plan will build upon the value based incentive methodology in use by the Wellmark ACOs. This use of the VIS to assess performance and to distribute additional financial incentives will allow for immediate alignment with existing commercial ACOs, which will help ease transitions for providers and help move Iowa toward greater alignment across all payers. During this initial phase, both providers and the State will have the opportunity to learn from the process, by beginning to learn how to most effectively utilize performance data to improve care, improve health, and reduce costs. Additionally, this initial phase provides an opportunity for the State, the ACOs, providers, and enrollees to adjust to the implementation of the ACOs and build and enhance the relationships, processes, and care coordination services that will be necessary to provide coordinated care across the physical health, behavioral health, and LTCSS systems before increasing their level of risk for costs and quality.

The reimbursement methodology will evolve such that the ACOs will have more risk and greater accountability for Total Cost of Care and quality measures. As the State moves into Phase II, within the statewide ACO model for Medicaid enrollees the reimbursement will shift to a model that includes greater risk (likely both up-side and down-side risk) and that continues to use the VIS, along with additional metrics designed to measure performance related to LTCSS and BH services. The ultimate goal is to move to a fully capitated system within five years. There will be clear and specific triggers and timelines for these changes in payment methodology and increased Total Cost of Care accountability.

## Increased Transparency

As part of the SIM work, the State will develop standard analytics and a model of distribution that provides the ACOs and their providers with access to the key metrics to which they are being held accountable as well as to patient level detail that is actionable. An example of the type of dashboard that can be developed appears below.

**Figure 47: Sample Dashboard Provided by Treo Solutions**



This centralized data function also will serve a role as the third party verifier of actual performance and quality of care provided. These standard analytics can and will become the singular point for all parties to the accountable care model to use to access metrics that will evaluate overall program performance. The transparent use of data will improve the quality of health care and reduce costs. Sharing of data across ACOs will be in aggregate only, and all data sharing will adhere to State and federal laws that regulate data sharing, including HIPAA and 42 CFR Part 2. The State's data analytics contractor as well as the IHIN will both support this data sharing.

Accountable care models encourage and expect providers to work together and take responsibility for the entire population or area they serve. Common metrics, adjusted for risk, provide a means to track performance, establish accountability, and fairly distribute incentive payments linked to performance. Risk stratification allows care management resources to be targeted.” Standard risk-adjusted metrics provide a means to track performance, establish accountability, and fairly distribute incentive payments linked to performance. More details about the metrics are provided in Section 12 and in the Self Evaluation Plan.

## **11. Future Status of Factors Impacting Population Health Status (Responds to Question 3)**

The State aims to transform the health care system into one that contributes to improvement of population health, and incorporates measures that accurately assesses population health status and are most closely related to health. In the new delivery model, the State proposes to leverage population health measures that are already being collected; ensure that there is a set of health status measures collected by all providers, regardless of payer; and support collection, analyses, and reporting of additional measures in order to have an accurate assessment of the health needs and health status of Iowans on an ongoing basis. As mentioned previously, the State is very interested in exploring ways to incorporate measures and accountability for non-health care related factors (such as socio-economic factors) that have a tremendous impact on health.

### **Provider Support and Ensuring a Sufficient and Appropriate Workforce**

Also important to improving population health status is ensuring that there is adequate workforce to provide care to those who need it, and that care coordination services are available and effective. As part of the transformed system, the statewide Medicaid ACOs will be responsible for providing technical assistance, training, and support to staff and providers to ensure they have the knowledge and skills to operate effectively in the new value-based system. Models of care provided through the ACO structure will be

developed using a team-based approach to serving vulnerable or high needs/high cost populations. Just having more physicians will not improve access nor will it reduce total cost of care. Successful care coordination models often use integrated care teams that may include a primary care physician, key specialty providers, a nurse care manager, a social worker, a health educator or community health worker, a nutritionist, a pharmacist, and behavioral health specialists as needed. Many of the services and supports needed by complicated, complex patients are not medical services; affordable and safe housing, transportation, adequate meals, and access to community supports and activities can be just as important and impactful to a Medicaid client as a visit to the doctor. Moreover, re-thinking who provides the care (i.e. a social worker or nurse practitioner might be more adept at care coordination and identifying social supports than a doctor) has the potential to mitigate access to care challenges resulting from medical provider shortages. ACOs will be held accountable in the transformed system for providing the right care by the right provider; IME will support the ACOs in developing mechanisms to do this and will encourage ACOs to share best practices as well as approaches and tactics that were unsuccessful. During workgroup meetings, several members that represented ACOs operating in the State indicated they have begun re-training some of the workforce to support them in new roles and responsibilities that will result from the shift in focus in the way health care services are delivered.

As mentioned elsewhere, Iowa is a rural state, and nation-wide it is becoming increasingly difficult to lure providers to rural areas. Iowa has two post-graduate medical schools: the University of Iowa and Des Moines University. Both of these schools have adopted programs that are designed to address the gap between supply of rural providers and demand for them. They have also both made changes to their curriculum to provide training in areas such as population health.

### **Des Moines University**

Des Moines University (DMU) is a private College of Osteopathic Medicine (COM) located in Des Moines. DMU has created the Rural Medicine Educational Pathway (RMEP) which provides specialized education, training and tools to better prepare students for service in rural, underserved areas of Iowa. This program is focused toward DMU's students and the primary care physician shortage, but has been expanded to provide opportunities for additional disciplines and academic institutions. DMU is addressing these issues through expanded relationships with rural physicians, hospitals and clinics to demonstrate the rewarding experience of rural medicine, particularly primary care. To address obstacles such as medical education debt load, DMU has made a commitment to annually provide the equivalent of four full-tuition scholarships to students enrolled in the RMEP. Scholarship eligibility is contingent upon completion of at least 40% of the third and fourth year clinical rotations in rural communities and maintenance of a full-time primary medical care practice in an Iowa community with a population of 20,000 or less for a period of up to four years (or one year for each year of full-tuition scholarship equivalents). DMU emphasizes placement in locations within the U.S. Department of Health and Human Services Primary Care Health Profession

Shortage Areas, Medically Underserved Areas and the Governor's Medical Underserved Populations Areas. To address the professional isolation and lifestyle which often discourage students from pursuing a career in rural medicine, DMU assigns each RMEP student a mentor who is an Iowa physician currently practicing rural medicine. These relationships begin while in school but provide an opportunity for on-going mentoring and support.

In addition to the standard DMU osteopathic medical school curriculum, the curriculum includes sessions on topics such as:

- Professionalism in rural healthcare practice
- Agricultural emergencies
- Building a rural practice incorporating the use of osteopathic manipulation
- Telemedicine and teleradiology

DMU has also changed its curriculum for all students to prepare them to practice medicine in the rapidly-changing healthcare environment. For example, they have added courses in preventive medicine and business management. DMU has also added degree programs in health and health systems management and health policy to produce future health care leaders.

### **University of Iowa Carver College of Medicine Rural Iowa Scholars Program**

In 2012, the University of Iowa Carver College of Medicine initiated the Rural Iowa Scholars Program (CRISP) to address the increasing physician shortage in rural areas of the state. CRISP is a comprehensive program that focuses on rural medicine throughout medical school. Students begin the program in the summer before their first semester by shadowing a physician mentor in a rural community. Rural elements are then embedded in the medical education through mentorships, seminars, research, and electives. Required clerkships lay the foundation for developing skills necessary to succeed as a rural practitioner. Each student has a physician mentor with whom they have monthly interactions throughout the four years of the medical program with in-person meetings at least twice each year. The mentorship includes focused discussions regarding career planning, especially during the final year of medical school.

CRISP was designed with the input of clinicians who are practicing in rural areas or who have strong interest and experience in rural medicine. By working closely with physicians who understand the issues facing practitioners in rural areas to design the program, the curriculum ensures participants gain the breadth and depth of experience and knowledge to maximize the likelihood of a successful career in rural medicine. The curriculum includes

- Shadowing experience with a physician in a rural community;
- Community Orientation program in which students are immersed in a rural medical community;

- Small group sections with faculty interested in rural medicine as part of the Foundations of Clinical Practice courses;
- A Rural Health and Agricultural Medicine course in their 2nd year and a telemedicine elective in their 4th year; and
- Continuity of Care experiences during the 2nd, 3rd, and 4th year of medical school, whereby students complete at least two continuity of care experiences at a rural site.

CRISP also supports students by paying for attendance at a state or national conference in rural medicine. Students are encouraged to participate in such conferences throughout their education.

Admission to CRISP is limited to four Iowa residents each year. Selection is based on prior exposure to rural life, demonstrated commitment to practice medicine in Iowa, demonstrated understanding of the roles and responsibilities of a rural physician, and personal characteristics important in the practice of rural medicine. A loan repayment program will be offered for CRISP students that match into an internal medicine, general surgery, family medicine, pediatrics, or psychiatry residency program and commit to practice in an eligible community (defined as one with a population of less than 26,000 and at least 20 miles from a city with population of 50,000) for a period of five years immediately after completion of graduate medical education. Students who match in an eligible Iowa residency program will receive \$20,000 in January of the first year of residency and \$16,000 per year after each of the first five years in practice in an eligible Iowa town. For those completing their residency training out of state, but returning and practicing in an eligible community immediately after completing their graduate medical education, \$20,000 per year will be given for a total of \$100,000.

The University also incorporates two full semesters of population-based and social health, and continues these themes within a continuous strand incorporated throughout the curriculum.

### **Iowa Rural Physician Loan Repayment Program**

In 2012 the Iowa Legislature created the Iowa Rural Physician Loan Repayment Program to help pay the loans of new doctors who agree to practice in rural areas of the State. The program is for communities located more than 20 miles from a city with a population of 50,000, and those communities must make a \$20,000 contribution to the rural Iowa primary care trust fund for each physician who comes there and takes part in the loan repayment program. Up to 20 medical students may enroll in the program every year. The legislature has funded this and communities must make a \$20,000 contribution to the rural Iowa primary care trust fund for each physician who takes part in the loan repayment program. Recently the University of Iowa Health Alliance today announced a one-million-dollar commitment over several years to support the program.

## **Collaboration with Community Colleges**

There are 15 community colleges operating 28 major campuses in the State. It has historically been the mission of community colleges to serve the individuals and institutions in the areas where they are located as well as to provide flexibility in schedules, settings and delivery methods for students. Courses and training are provided throughout the year in time-frames that go beyond the typical “two semesters and a summer” format of four-year schools. This allows individuals to start their training when it is most convenient for them. In Iowa, it does appear that the community colleges are providing education to many Iowans who are pursuing careers in health care. In fact, Iowa is 12th in the nation in degrees awarded in non-nursing health programs. However, in a National Center for Higher Education 2004 presentation, presenter Patrick J. Kelly identified Iowa as being a “High Production/Exporter of Capital” in describing the state’s ability to produce graduates versus its ability to keep and attract graduates. This out-migration is greatly contributing to the shortage of health care workers and is a result of the challenges of working in small communities, loan burden and low pay. As part of the SIM work, the State will assess the best way to collaborate with community colleges to ensure they continue training health care professionals and to identify activities to encourage these workers to stay in Iowa.

## **Iowa Health Workforce Center**

The IDPH coordinates public and private efforts to develop and maintain an appropriate health care delivery infrastructure and a stable, well-qualified, diverse, and sustainable health care workforce in Iowa. Through the work of the Department, the State has developed a strategic plan for health care delivery infrastructure and health care workforce resources in Iowa; provided for continuous collection of data to provide a basis for health care strategic planning and health care policymaking; and made recommendations on the health care delivery infrastructure and the health care workforce that assist in monitoring current needs, predicting future trends, and informing policymaking. The Iowa Health Workforce Center is the IDPH unit designed to coordinate this work. The Iowa Health Workforce Center has established a new mission and strategic goals consistent with recommendations from stakeholders obtained at the Health and Long-Term Care Workforce Summit in November 2007 and with guidance from the Health and Long-Term Care Access Advisory Council. The attendees at the Health and Long-Term Care Workforce Summit developed several recommendations:

1. Establish the Iowa Health Workforce Center;
2. Expand loan repayment programs;
3. Continue efforts to increase Medicare and Medicaid reimbursement so providers can pay competitive wages;
4. Maintain infrastructure (a center) established for coordination of health and long-term care workforce efforts (as established in recommendation #2 above);
5. Continue to sustain recruitment/retention/training programs that are working, adjust those not working and develop new ones to address emerging workforce needs;

6. Align licensure scope of practice with scope of practice taught in education programs so that mid-level professionals are permitted and expected to maximize their training and skills;
7. Continue and expand efforts toward wellness and prevention, a health care system rather than a sick care system, to reduce demand; and
8. Maximize best practices and efficiencies in how professionals deliver services and communicate with one another.

Many of these recommendations have been put in place, including numbers 1 and 2. The SIM work aligns nicely with many of recommendations in that it encourages the use of non-physicians where possible, focuses on wellness and prevention, will support health professionals in being more effective in delivering services and communicating with one another.

## **Creation of a Reinvestment Fund**

During the last round of workgroup meetings, stakeholders expressed support for the idea of a reinvestment program, similar to the program currently in place as part of the Iowa Plan. With this program, the Medicaid Behavioral Health Care Managed Care Organization is required to set aside money to support innovation and priority objectives. Workgroup members recommended that the ACOs and the State be required to contribute some portion of any realized savings into a fund in order to make longer-term investments into the community. Although no specific uses of the money were articulated, there were suggestions that the focus be on making adjustments to longer-term cost drivers, which would also have an impact on longer-term population health status. For example, ensuring the health and proper development of children will have tremendous savings in a few decades (rather than a few years). Alternatively, the fund could be used to support innovation in the ACO delivery system. The State is considering this recommendation and exploring ways to implement it and select the best use of the monies collected.

## **Technology Transfer and Diffusion of Innovation and Best Practices**

While the ACO model itself encourages entrepreneurship and innovation within individual ACOs, there also should be a structure for the transfer of lessons and technology across different ACOs – and an ability to use the collective experiences to identify opportunities, challenges, and needs as they relate to different populations. Again, such an approach may have particular relevance to serving children where the benefits from improving health may be the greatest in terms of overall health demands and costs but occur over the long-term. It also may have a particular relevance in terms of the broader concerns for developing a health system which responds holistically and addresses social, as well as biomedical, determinants of health.

## **Governor's Healthiest State Initiative and the Blue Zones Project**

The Healthiest State Initiative is a privately led public initiative which requires partnership between the public sector, individuals, families, businesses, faith-based organizations, and not-for-profits, to improve healthy behavior within communities. This is part of Governor Branstad's goal to make Iowans healthier and happier and to ensure Iowa is the healthiest state in the nation by 2016 by the standards of the Gallup-Healthways Well-Being Index. The Index measures Daily Pulse, Life Evaluation, Emotional Health, Physical Health, Healthy Behaviors, Work Environment, and Basic Access.

The Initiative's website: <http://www.iowahealthieststate.com> provides resources and suggestions for improving health, such as gardening at home and forming walking groups for exercise. There are also several core components such as the:

- Healthy and Happy Outdoors (H2O) Iowa program, which is structured to encourage people to use outdoor space more frequently in order to improve health and reduce stress; and
- Complete Streets policy initiative, which is meant to improve roads for all types of users - pedestrians, motorists, and bicyclists.

By using many of the same suggestions and goals, the Governor's Healthiest State Initiative is aligned with the Blue Zones Project,<sup>120</sup> a community-by-community well-being improvement initiative designed to make healthy choices easier through permanent changes to environment, policy, and social networks. The focus is to lead longer lives through good health practices. Currently Cedar Falls, Cedar Rapids, Mason City, Muscatine, Sioux City, Spencer and Waterloo are Blue Zones Communities. In addition, nineteen Iowa communities have been selected to receive support from experts to become Blue Zone communities; more will be selected in the future.<sup>121</sup>

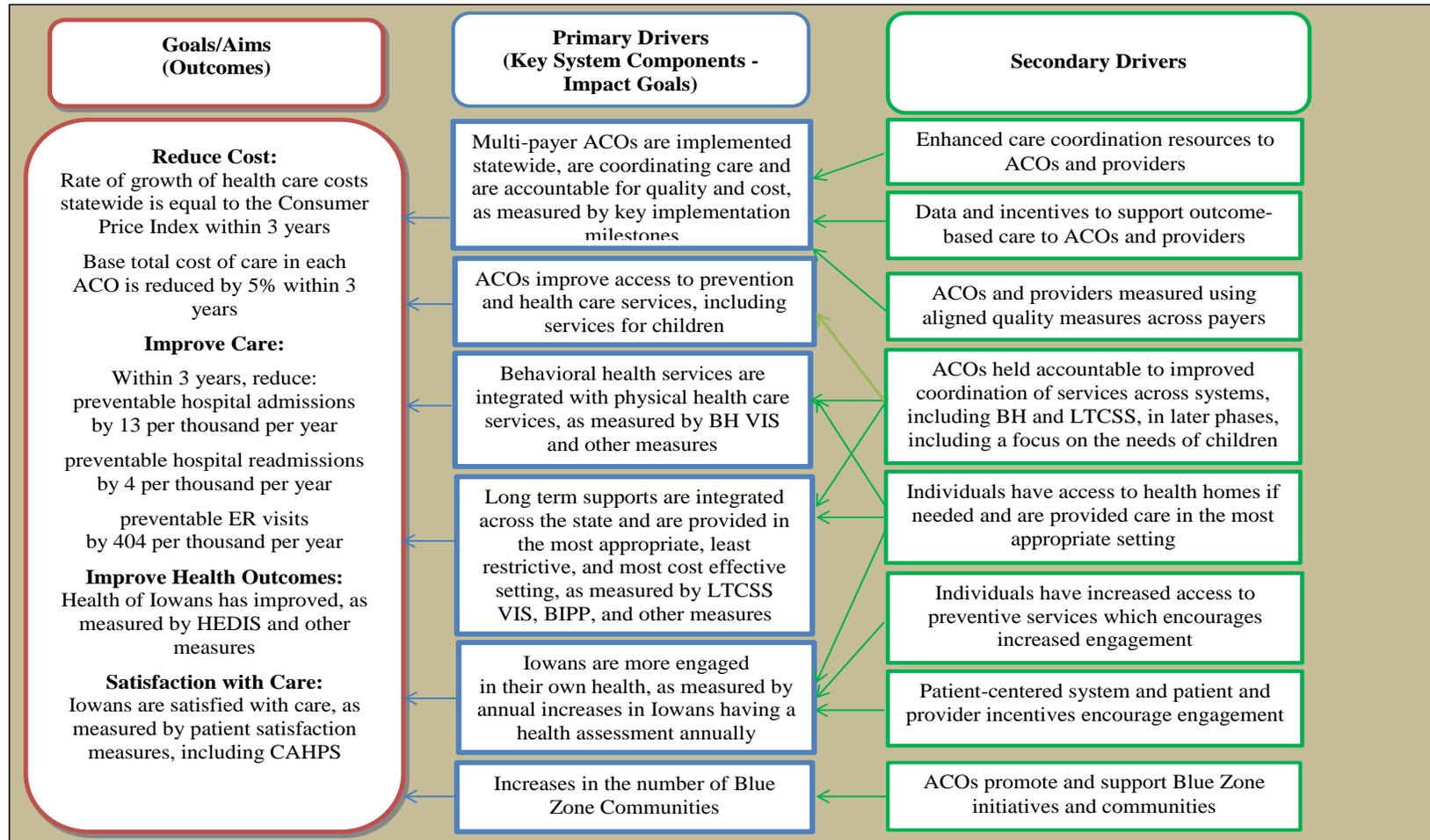
The SIM project will leverage these initiatives in several ways. First, ACOs will be required to develop and implement plans to engage the people they serve in prevention-related activities, and these resources will be an important part of the array of services to which ACOs will refer individuals they serve. Second, as Iowans begin to engage in more Blue Zone or Healthy Iowa activities, they will begin to take more ownership of their health, which will make them more likely to engage in preventive services provided by primary care providers and coordinated by ACOs. In these ways, the work of the SIM project and the work of these initiatives are mutually supportive.

## **12. Cost, Quality, and Population Health Performance Targets (Responds to Questions 12 and 13)**

Iowa's cost, quality, and population health performance targets for its transformed health system include a focus on the triple aim: improving the individual experience of care; improving population health; and reducing the cost of care. To achieve these goals, the strategies and activities described throughout this SHIP will be implemented.

The primary and secondary drivers that will lead to achieving these goals are illustrated in the driver diagram below and are described in detail here and throughout the SHIP. Specific targets are described below as are the measures, data sources and proposed analyses. Additional targets are likely to be added as the project continues to evolve in the upcoming months and as the project begins to be implemented within a constantly evolving healthcare environment.

**Figure 48: Driver Diagram**



Many of the measures described here are part of the VIS that is currently used by the Wellmark ACOs in Iowa. Iowa intends to build upon and leverage this existing system of measurement as a core part of its self-evaluation, and as a core part of its measurement of the effectiveness of the ACOs. Using these measures as a core set of measures has the added benefits of further aligning payers across Iowa, and measuring performance across many domains, from prevention to healthcare system processes and delivery, to population health outcomes of interest. All measures (with the exception of patient experience of care) are driven from claims data, so for most data, no special collection or processing is needed in addition to claims filing, which is another benefit. Additionally, many measures align with CMMI's priority measures.

Another benefit of using the VIS as a core part of the measurement is that the VIS can provide a single composite value that pulls together various measures into a single score that represents a comprehensive look at a primary care practice. Each domain includes well-researched measures that can be influenced by changes in provider behavior. While each domain can be viewed on its own, the VIS also offers an overall score that can be used to rank provider performance and to compare a provider's score to the overall average score for the system or network, which helps to pinpoint areas that may require more scrutiny for performance improvement. Additionally, the measures can be used by the ACOs to help provide additional support to providers as needed. Importantly, measures can be aggregated to the ACO level to measure ACO performance, and to the state level to measure statewide healthcare system performance and changes in population health.

**Table 34: VIS Measures**

Domain	Measurement Value	Metrics
Member Experience	Assessing and improving patient experience has positive impacts on clinical outcomes.	<ul style="list-style-type: none"> <li>• How's Your Health (HYH)</li> <li>• Client Specific Member/Patient Surveys</li> </ul>
Primary and Secondary Prevention	Increased educating, motivating, immunizing, and screening prevents disease.	<ul style="list-style-type: none"> <li>• Breast Cancer Screening</li> <li>• Colorectal Cancer Screening</li> <li>• Well Child Visits Birth to 15 Months</li> <li>• Well Child Visits 3-6 Years of Age</li> </ul>
Tertiary Prevention	Good access to primary care reduces the incidence of ambulatory care sensitive admissions and ER visits.	<ul style="list-style-type: none"> <li>• Potentially Preventable Admissions (ACSC Proxy)</li> <li>• Potentially Preventable ER Visits</li> </ul>
Population Health Status	Combined impact of good primary care will delay disease progression in chronically ill.	<ul style="list-style-type: none"> <li>• Chronic Complexity Non-Jumper</li> <li>• Chronic Severity Non-Jumper</li> </ul>

Domain	Measurement Value	Metrics
Continuity of Care Domain	Consistent patient engagement and coordination of care produces higher rates of adherence, identification of health problems, and patient satisfaction as well as lower hospitalizations, emergency room use, and total cost of care.	<ul style="list-style-type: none"> <li>• PCP Visits</li> <li>• Qualified Physician Visits</li> <li>• Continuity of Care Index</li> </ul>
Chronic and Follow-Up Care	Follow up care reduces readmissions and a regular source of chronic care improves patient outcomes.	<ul style="list-style-type: none"> <li>• 30 Day Potentially Preventable Readmissions (Not all cause readmissions)</li> <li>• PCP Visit 30 Days Post Discharge</li> <li>• 3 Chronic Care Visits</li> </ul>
Efficiency Domain	Efficient use of resources reduces burden on patients and directs health care time and money to more productive patient care.	<ul style="list-style-type: none"> <li>• Potentially Preventable Service Dollars</li> <li>• Generic Rx prescribing rate</li> </ul>

The VIS measures are not the only measures that will be utilized. Measures of cost, additional measures of client satisfaction, measures of integration of care across systems (including behavioral health and long term care supports and services), care coordination, and other measures will be incorporated into the overall evaluation of the SIM work and the transformed healthcare system to provide a comprehensive picture of what is working well, what needs to be improved, and the overall health of Iowans. Measures that are specific to children are being explored and will be included, as will measures that relate specifically to meeting behavioral health needs and LTCSS needs. These additional measures are described below.

## Targets for Reducing Cost

In terms of costs, Iowa initially proposed has two primary targets. The first was to reduce the rate of growth of health care costs statewide to the Consumer Price Index within three years. The second cost target for Iowa's transformed system was that total healthcare costs within the ACOs would be reduced by 5-8% within three years. During the fall of 2013, Milliman, Inc. conducted actuarial analyses using Medicaid data only to estimate total cost of care savings that may be possible via the ACO model that is being developed as part of this SIM work. High level analyses are showing that a 5% reduction in costs over four years may be possible utilizing the ACO model. However, these preliminary analyses did not include Medicare data, it is possible that additional cost savings may be realized. As ACO activity continues to grow and expand, it is anticipated that there will be even more efficiencies realized within the overall system. Additional analyses will continue in efforts to determine how additional cost savings may be possible.

Data to calculate total cost of care statewide will come from Medicaid, Medicare, and Wellmark's ACOs claims data. While this will not capture costs for every individual in

Iowa, it will capture costs over 80% of Iowa's population, because Medicaid, Medicare and Wellmark's existing ACOs cover that percentage of the population, and it is anticipated that this percentage will continue to grow. These data are collected on an ongoing basis already. In order to attain a total cost of care across all three systems, it is anticipated that, in the short term, each system (Medicaid, Medicare, and Wellmark) will continue to be responsible for analyzing their own data, but that risk-adjustment and trending methods will be consistent across systems so that data analyses can be aggregated to generate the total costs of care. A goal for the more distant future is the development ways to enhance transparency of information, allow for more efficient data collection, analyses and utilization across payers. Data to calculate total cost of care within the ACOs will come from Medicaid claims data for each ACO. As with statewide costs of care data, these data are already collected on an ongoing basis (claims data). Data will be analyzed by the State or by a vendor selected to perform data analytics for the SIM implementation work.

## Targets for Improving Care

Iowa has many goals for improving care for Iowans. Among these are ensuring continuity of care for Iowans and reducing the incidence of preventable events. While not all of the goals for improving care will be measured initially, several key targets will be measured, including preventable hospital readmissions, preventable hospital emergency room (ER) visits, and measures of continuity of care.

### Preventable Events

Iowa is committed to reducing potentially preventable events as part of its overall strategy to improve care and reduce cost. Preliminary analyses suggest that the following goals may be achievable: reducing preventable hospital admissions by 13 per thousand people per year (PKPY) statewide within three years, preventable hospital readmissions by 4 PKPY statewide within three years, and a reduction in preventable emergency room visits by 404 PKPY statewide within three years. More analyses are ongoing to determine the most appropriate goals.

Two of the VIS measures currently in use by Wellmark ACOs, upon which the new ACOs will be measured and held accountable, are measures of preventable hospital readmissions and preventable hospital emergency room visits. Within the VIS, these two measures make up the domain of "tertiary prevention". These measures are represented in the driver diagram as part of the measures of improving care, and these measures align with CMMI's concept of measuring healthcare services (as part of the process measures).

These measures evaluate the effectiveness of providers in responding to episodes of illness through adequate access and high quality primary care. Both measures will be analyzed by examining all readmissions and ER visits for enrollees in the ACOs (using claims data) and conducting analyses on the rates of these preventable events from year to year, by ACO, by provider, and statewide. ACOs will be held accountable for

reducing preventable readmissions and ER visits within three years. After year three, ACOs will be financially at-risk for reducing preventable hospital readmissions and ER visits. Comparisons of rates of preventable events will be risk-adjusted, and analyses will include an examination of disaggregated data by demographic to assess differences in outcomes for different subpopulations.

## **Continuity of Care**

To measure progress in ensuring that all Iowans have access to and are provided continuous care, Iowa will utilize the VIS measures of continuity of care. The measures in this domain measure the concentration and consistency of physician visits. It has been found that members with high continuity of care rates are generally associating to lower hospitalization and readmission rates, more efficient medical care and greater patient satisfaction. Specifically, the continuity of care measures include: the percent difference between the expected continuity of care score for providers serving similar populations and the actual score for the provider's panel; percent of a provider's panel visiting a primary care provider (PCP) and the percent of a provider's panel that had a visit with physician during the year.

The State, or a vendor hired to analyze these data will analyze Medicaid claims data to determine performance on these measures, aggregating to the level of the ACO (and to the region if there is more than one ACO in a region), and then to the state, to assess ACO performance and statewide performance. Essentially, the State (or its data vendor) will examine Medicaid claims data to determine the percentage of Medicaid enrollees who are "attributed to" or linked with a primary care provider or medical home. Second, the State or the vendor will examine claims data to determine the percentage of individuals who had at least one primary care or preventive visit in a year. In addition, the state or the vendor will conduct a full analysis of claims data to determine the providers with whom each client visits the most, in order to assess whether individuals have an appropriate source of primary care. Analyses will include an examination of disaggregated data by demographic to assess differences in outcomes for different subpopulations.

For clients served by Medicare or by Wellmark's ACOs, a similar analytic process will be conducted by these systems to round out the picture for the majority of Iowans who are covered by these three systems. Again, over time, the State intends to work toward even more transparency in data, and more efficient and effective processes for analyzing and utilizing data across the state and across payers and systems.

## **Care Coordination**

Another area of measurement related to improving care is that Iowans are provided with appropriate care coordination services. The State plans to require that each ACO provide a plan for identifying the care coordination needs of all individuals it serves, ensuring that appropriate care coordination services are provided, and providing evidence on an ongoing basis to the State that both have occurred. Contracts with

ACOs will include monitoring and reporting requirements related to care coordination activities, services, and outcomes for clients and ACOs will be held accountable for ensuring that care coordination services are provided.

Potential measures to which ACOs will be held accountable may include but are not limited to: the percentage of individuals who have a care plan (including transition plans and plans for follow-up as needed); the percentage of referrals for additional tests or to specialists that are completed; and the percentage of providers who have processes in place to ensure adequate communication between specialists and primary care provider, among others.

Additionally, patient satisfaction measures that are part of the VIS will be utilized to measure quality of care coordination and continuity of care. Analyses will include an examination of disaggregated data by demographic to assess differences for different subpopulations. The state is also exploring the utilization of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey as part of this work, potentially with a sample of higher need clients.

Additional measures of continuity of care and care coordination will come from the VIS. The VIS measures two key elements of care coordination. First, for people who are admitted into the hospital, did they receive proper follow up attention to the incident? Second, for people who have chronic conditions, do they receive appropriate care to help manage their conditions after discharge from the hospital? One measure of this is potentially preventable hospital readmissions, which was discussed above. Another measure is the percentage of hospital discharges that have a physician visit within 30 days of discharge. A third measure is the percentage of people with chronic conditions that have three or more physician visits within a year. While these measures do not provide the full picture of whether an individual's care coordination needs are met, they do provide some indication of provision of needed and appropriate services and can be used as both a proxy for care coordination and as a way to identify potential areas of unmet need.

### **Appropriate Use of Services**

Another measure of quality of care that the State will utilize, again based in the VIS, is related to the appropriate use of outpatient and professional services. The VIS includes an analysis of claims data of potentially preventable ancillary services, such as high cost imaging like an MRI, ordered by primary care physicians or specialists that may not provide useful information for diagnosis and treatment (e.g., MRI for back pain), and physicians' appropriate use of generic drugs.

All of these measures rely on claims data. As with other measures, the State or its vendor will analyze Medicaid claims data on an ongoing basis, and will disaggregate data to look at specific subpopulations, and will aggregate measures to the ACO level to assess ACO performance, and to the state level to assess statewide progress. The State will hold ACOs accountable for their providers meeting certain targets for these

measures. The ACOs will have both the incentive to support providers in meeting these targets, and the resources to provide necessary support to providers. Additionally, the State will aggregate data to the state level to measure statewide performance and overall population health.

## Targets for Improving Satisfaction with Care

Iowa's goal for its transformed healthcare system is that Iowans are satisfied with their care, as measured by patient satisfaction measures included in the VIS, which includes measures of patient confidence in their care, and patient perceptions of continuity of care, office efficiency and their access to care. These data may be collected via a survey adapted from the "How's Your Health" survey, developed by John Wasson, MD, Professor of Community and Family Medicine, and Medicine at Dartmouth Medical School, or may be collected via the CAHPS survey. The State anticipates administering the survey with a sample of patients across all ACOs, mostly likely on an annual basis. Data will be analyzed by the ACOs and the State and used to monitor patient experience of care and to drive continuous quality improvement. It is anticipated that each ACO would be required to administer patient satisfaction surveys (either the CAHPS, the "How's Your Health" survey, or another approved survey) annually to a random sample of individuals they serve, across providers. The specific sampling strategies will be developed and specified prior to finalizing ACO contracts, and details about sampling, survey administration frequency and methods, and analyses will be included in the contracts. As with other measures, analyses will include a look at differences by subpopulation and these analyses will be used to improve service delivery.

## Targets for Improving Health Outcomes

Iowa has a number of targets related to improving health outcomes, as discussed throughout this SHIP.

A target that is measurable within the VIS is the reduction in the number and percent of Iowans with chronic conditions. Another is a reduction in the severity of chronic conditions. The VIS measures for these two targets use a risk-adjusted assessment of the percent difference between the expected rate of disease progression and the actual rate of the disease progression in the provider's patient panel. These measures mirror CMMI's priority area around outcomes ("functional and health status change"). The state anticipates utilizing HEDIS measures to monitor and track changes in health outcomes. Measures related to the health of children are also being explored. Additionally, the State is planning to incorporate state-level population health measures, particularly measures that are collected through the Behavioral Risk Factor Surveillance System (BRFSS). The IME plans to work with the Iowa Department of Public Health to explore the best ways to utilize these data to measure statewide progress toward SIM goals, and to measure progress within each ACO region. BRFSS measures of particular

interest are measures related to tobacco use and obesity, particularly among adolescents and children.

## **Primary Drivers**

In order to achieve the goals and targets described above, a number of activities will be occurring throughout the State, as described throughout this SHIP. These primary drivers are that regional ACOs will be developed and implemented across the state, and ACOs will begin to be accountable for quality and cost targets. ACOs will provide support to their providers in transforming their delivery of care. In later phases, behavioral health services and long term care supports and services will begin to be more integrated and ACOs will begin to be held accountable for this integration and coordination. ACOs and providers will work with other entities to help engage Iowans more in their own health and play a more active role in becoming healthier.

The State will measure success *toward* implementation of these drivers (process measures, or implementation milestones), and will measure the success *of the implementation* of these drivers. In other words, the State will measure both the process and outcomes related to these drivers. For example, a milestone or process measure related to the implementation of the ACOs would be that the procurement process for the ACOs occurs on time. An outcome measure related to the implementation of the ACOs would be that a certain percentage of Medicaid enrollees in an ACO's region has been attributed to a primary care provider and has had a visit with that provider. Potential measures for each of the primary drivers are provided below, along with information about the sources for the information and plans for analyses and use of the information.

## **Multi-Payer ACOs**

The ACO model provides an opportunity to transform Iowa Medicaid into a patient-centered system that provides more coordinated and integrated care, improves the patient experience of care, achieves better health outcomes, and reduces cost. The State's overall vision is to implement the multi-payer ACO methodology across Iowa's primary health care payers. Iowa's goal for the SIM project is to create delivery system change and payment reform that provide quality care, improves health outcomes, and reduces health care costs for the State as a whole. Development of multi-payer ACOs is a key driver of system transformation. ACOs will provide the backbone of the transformation efforts, by providing support to providers, ensuring continuity of care and appropriate care coordination services are available and provided to Iowans, and by working toward the goals of improved health outcomes, improved care delivery, and reduced costs.

Key measures of the success of this driver will be both process measures, in the form of meeting implementation milestones, and outcome measures, in the form of the health outcome, cost, delivery system, and patient satisfaction measures discussed throughout this section.

Key implementation milestones are provided below. The State will continuously monitor progress toward meeting these milestones and will work to mitigate challenges and delays. Outcome measures are discussed throughout this section.

## **Behavioral Health Services**

The integration of behavioral health care services and physical health care services is a critical driver toward better patient-centered care, improving patient experience of care, achieving better health outcomes, and reducing cost. Integration of care will improve care coordination for patients and communication between different providers, resulting in better care and better health outcomes. Part of the work of the SIM, therefore, is to increase integration of behavioral and physical health care services, using the ACO model. While this integration will occur in a later phase of the work, the State will begin paving the way for this integration from the beginning of the work. In fact, this work has already begun through the stakeholder process by creating a work group that specifically focused on developing recommendations for integration of behavioral health with physical health services, including recommendations around service delivery and measurement.

Goals related to this driver include providing care in the most appropriate setting, ensuring that all individuals with SPMI or SED have access to primary care and preventive care that they need, building upon and utilizing existing initiatives, such as Integrated Health Homes, and having a well-developed stakeholder engagement process throughout all phases, including planning, design, development, implementation and on-going monitoring.

Measures of the success of this driver may include measures that have been identified through the Mental Health Redesign Project, including measures related to medication management, enrollee engagement in planning services and support, and provision of services that support resiliency and recovery.

In addition, the state may incorporate measures of ACO readiness to coordinate behavioral health services, as a precursor to ACO's being held accountable for these costs in the total cost of care calculations (TCOC) and in quality requirements and goals. The State is exploring the following. In the first year of the implementation of the SIM model, ACOs will not be held accountable for behavioral health services in the TCOC calculations. In the second year of the SIM work, behavioral health services will be added to the TCOC calculation if an ACO's performance on certain behavioral health measures improved by a predetermined percentage point in the previous measurement period. In the third year of the SIM work, a similar process will be followed for long term care supports and services. The state may also increase the maximum for the shared savings in years 2 and 3 if an ACO achieves these goals. This process will encourage ACOs to increase their readiness, and will allow for flexibility in adding accountability for these services.

## **Long Term Supports and Services**

The integration of long-term care services and supports (LTCSS) into the ACO value-based framework is another critical driver of change across Iowa's health care system. This integration will reduce duplication of effort and increase use of home and community-based services, thereby lowering use of more costly institutional services and allow beneficiaries to remain in their homes and communities. The success of the ACO model in Medicaid will be determined by the State's success in being able to integrate care for the highest cost/highest risk populations with very intense needs for social and community-based supports. As the primary payer for health and community-based supports for persons with disabilities, the State has sufficient leverage to influence delivery system change.

Goals related to this driver include reducing hospital admissions through the use of accountable, coordinated care, shifting utilization from institutional care to Home and Community Based Services (HCBS) thereby lowering all costs; using existing initiatives, such as the Balancing Incentives Payment Program (BIPP) to facilitate transformation of the LTCSS to one that includes BIPP required components such as: (1) no wrong door/single point of entry; (2) conflict free case management; (3) use of a core standardized assessment instrument; and having a well-developed stakeholder engagement process throughout all phases, including planning, design, development, implementation and on-going monitoring.

A primary measure of the success of this driver will be the degree to which the ACO model is effective at balancing long term care service delivery, in alignment with the BIPP. Additionally, the State is exploring the inclusion of the process described above regarding behavioral health measures, in which ACO's readiness to coordinate LTC services will be measured and adjustments to the rate at which total cost of care calculations includes these services will be made, along with potential adjustments in shared savings.

## **Enrollee Engagement**

Another critical driver of transformation in the Iowa healthcare system is an increase in engagement by enrollees. True health reform must be led by individuals becoming healthier and taking ownership of their own health and well-being. The Governor has set the goal for Iowa to become the healthiest state in the nation by 2016 and has established the Healthiest State Initiative. The initiative seeks to improve the health of individuals by encouraging active lifestyles and healthier choices. The SIM project includes incentives to encourage providers to improve engagement of the individuals they serve, and incentives for individuals to encourage them to participate more in their own care.

A primary measure of the success of this driver will be the number and percentage of enrollees who achieve the health behavior program and bypass cost-sharing in year 2 of enrollment in the Iowa Health and Wellness plan. IME is also considering a measure

of success related to the number and percentage of enrollees who have a health assessment each year, similar to the measure that will be part of the Iowa Health and Wellness Plan. The IME intends to learn from the use of this measure in the IHAWP before implementing it as part of the SIM work.

### Secondary Drivers

Secondary drivers, or specific resources and activities that build toward achieving the primary drivers and, ultimately, the targets and goals for the project include the following. Measures of each of these drivers are discussed here as well, along with access to data and plans for analyses and utilization of the data. While estimates of cost savings and improvements in health outcomes associated with each driver have not yet been completed, work to determine these estimates will be part of preparation for the SIM Model Testing Grant proposal and to prepare for implementation.

1. Enhanced care coordination resources will be provided to ACOs and providers

ACOs will be provided a per member per month (PMPM) payment to ensure care for Medicaid enrollees in their region is coordinated and effective, and to provide support to primary care providers who are providing care to these individuals. The State will provide this PMPM to the ACOs. This funding is anticipated to be a driver of system change by providing the necessary resources to the ACO to enhance care coordination and service delivery and by holding ACOs accountable for cost and quality measures as part of their contracts.

The State will have access to the data on PMPM amounts per ACO on an ongoing basis. Analyses will be conducted at least annually, and will include basic descriptive analyses (i.e., funding per ACO and statewide) and the data will be included in other analyses to help assess the impact of this funding on changes in the healthcare delivery system, and changes in health outcomes and healthcare costs that result from changes in the healthcare delivery system.

2. Incentives for outcome-based care will be provided to ACOs and providers

The State may also pay incentives to the ACOs and, indirectly, to providers for achieving quality and total cost of care goals. Incentive payments are a driver of system change by rewarding value-based service delivery, rather than volume-based service delivery. Together, the PMPM payments provide resources to help drive system change and the incentive payments provide additional incentives for all parties to work to move the entire system toward a value-based system with improved quality and health outcomes and, over time, lower costs.

Similar to the collection and use of the PMPM data, the State will have access to these data on an ongoing basis, and will use the data as a process measure and as part of analyses related to goals and targets.

3. ACOs and providers will be measured using aligned quality measures across payers

The quality measures to which ACOs and providers will be held accountable are described in detail above. These will include the VIS measures, and may include other measures described throughout this document. Alignment of some core measures across providers and payers will be a driver of system change because, as providers and payers all begin to work toward the same goals, the system will begin to move in a more coordinated fashion in that direction, rather than potentially working in opposition. Alignment of some core measures will provide more clarity for providers and for ACOs. Aligning these measures with incentive payments provides additional assurance that the system will move in the intended direction. How these quality measures will be collected and analyzed is described in detail above. Most data will be generated from claims on an ongoing basis, with analyses and reporting monthly, quarterly, or annually, depending on the measure. Reports, updated monthly, will be shared with providers and ACOs to assist in their continuous improvement efforts.

4. Providers and ACOs will be held accountable to improved coordination of services across systems and for continuity of care, including a focus on the needs of children

Holding providers and ACOs accountable specifically to improved coordination of services across systems, and for continuity of care, is one of the key drivers of change. By ensuring continuity of care and identifying care coordination needs, ACOs and providers can provide appropriate prevention services, follow-up care, referrals and other services to improve health outcomes. This will include a focus on the needs of special population, including children and adolescents.

As part of the SIM work, the state and its vendor are developing a data dashboard that will allow timely access to actionable data for ACOs and providers. Data to measure how effective ACOs and providers are at these activities are described in detail above, and include measures of care plans, follow-up plans, and appropriate physician visits following hospitalization or to manage chronic conditions. These measures come from claims data. For Medicaid enrollees, the State has ongoing access to these data. For Medicare enrollees and Wellmark ACO enrollees, work is in process to facilitate this kind of analyses and reporting. Reporting will be monthly or quarterly. Both the data dashboard and reports will be available to providers and ACOs to assist in their continuous improvement efforts.

5. Individuals will have access to integrated health homes if needed and will be provided care in the most appropriate setting

A key driver of change in the Iowa healthcare system will be the continued and increased utilization of integrated health homes (IHH) for those who need it, and the provision of care in the most appropriate setting. For those that need an integrated

health home, the IHH will provide the most appropriate and helpful care coordination services and care, and will ensure that care is provided in the most appropriate setting. By doing so, adults with severe mental illness (SMI) and children with severe emotional disturbance (SED) conditions will be able to manage these conditions more effectively. Providing appropriate care for people with SMI or SED provides an important opportunity for Iowa to create significant change in the system, both in terms of improving care and health outcomes, and in terms of cost savings that can be realized by eliminating duplicative or unnecessary services.

Measures of access to integrated health homes will include data that identify the number of Medicaid enrollees who meet the requirements for enrolling in an IHH, and the number of these individuals who have access to and utilize an IHH.

6. Individuals will have enhanced access to preventive services, and will utilize these services at higher rates, which will improve long term health outcomes and will encourage increased engagement in their own health

The VIS measures include several measures related to prevention, and ACOs will be held accountable for these measures. As examples, included in the VIS are measures of percent of pediatric well-visits for children up to 15 months old, and from 3 years to 6 years of age; the percent of mammogram screenings for applicable individuals; and the percent of colorectal cancer screenings for eligible patient individuals.

To further measure access to and provision of preventive services, the State anticipates utilizing Health Effectiveness Data and Information Set (HEDIS) measures. Based on the analyses conducted of the current state “as is” health of Iowans, the following areas of prevention are critical to improving the health of Iowans. These measures also align with CMMI priorities and may include: adolescent immunizations, childhood immunizations, Human Papillomavirus Vaccine for Adolescent Females, Prenatal and Postpartum Care Visits, Comprehensive Diabetes Care, Blood Pressure Control, Cholesterol Management for patients with cardiovascular conditions, Adult BMI Assessment, Weight Assessment, Nutritional Counseling, and Physical, Activity Counseling, Colorectal Cancer Screening. While ACOs will not be at-risk financially for their performance on these measures initially, the measurement will allow the State and the ACOs to identify areas in need of improvement in order to achieve the goals for the transformed health care system.

The State is exploring the addition of specific measures related to children as well, including measures of access to specialists, and measures of the utilization of preventive measures and screenings specific to children and adolescents. Although most children are not drivers of high cost today, requiring ACOs to invest in children now ensures long term sustainability for improved outcomes and savings.

7. The healthcare system will be patient-centered, and patient and provider incentives will encourage engagement

A key goal for the system is that Iowans are more engaged in, and feel more responsible for their health and healthcare. Providing incentives to both patients and providers to encourage patient engagement will be an important driver to transform Iowa's healthcare system, and aligning these measures across providers and patients is critical. For example, in alignment with the Iowa Health and Wellness Plan, as part of the SIM work, the State may provide incentives to providers based on a target for their patients completing an annual wellness exam, and provide incentives to individuals to complete these. By aligning these incentives across both individuals and providers, achieving the goal of greater patient engagement is more likely. This alignment, coupled with the SIM work to integrate public health efforts around individual engagement in health (see discussion of Blue Zones initiatives below), will have a tremendous impact on health outcomes and, ultimately, cost savings by ensuring that more Iowans participate in early prevention activities, that rates of physical activity increase and that rates of smoking decrease, for example.

Measures of individual engagement may include the number and percentage of clients who have a wellness exam and the number and percentage of enrollees who have completed a health assessment. The state is exploring more measures to encourage engagement in the new healthcare delivery system.

8. ACOs will promote and support Blue Zone initiatives and communities

Another driver of system change will be ACO support and promotion of Blue Zone initiatives and communities. The Blue Zones Project is a community-by-community well-being improvement initiative designed to make healthy choices easier through permanent changes to environment, policy, and social networks. The focus is to lead longer lives through good health practices. There are 9 guiding practices of the Blue Zones Project (called Power 9). To become a Blue Zones Community, a percentage of each of the six sectors (individuals, community, employers, locally-owned restaurants, public schools, grocery stores) is certified to have met certain standards/activities. Individuals pledge to take certain steps in their communities to improve their own health/lives and the government puts into place a certain percentage of the policies recommended by the Blue Zones project (smoke-free zones, etc.).

9. Social determinants of health are important drivers of health outcomes. These factors impact health across the life span

## Iowa's Self-Evaluation

As part of the development of the SHIP, the State has developed a self-evaluation plan to guide data collection and analyses that will achieve several goals. While some narrative in this section may be duplicative, this self-evaluation section is designed to be

a part of the SHIP document that the State will use in the future as part of its ongoing efforts to measure, track, and improve its SIM efforts. The self-evaluation plan will help the State stay focused on, and monitor progress toward, meeting implementation milestones. The self-evaluation plan will also help the State and others monitor progress toward its overall SIM goals of reducing costs, improving quality of care, and improving the health of Iowans. Last, the self-evaluation plan will assist with CMS's efforts to conduct a cross-site evaluation of all of the SIM work.

The measures and the analyses were discussed above. In this section, an overview of the evaluation plan is provided, along with a summary of the data sources, who will be responsible for data collection and analyses, how data will be used, and how the evaluation will coordinate with CMS/CMMI efforts and aligns with other national measurement initiatives.

The work of estimating the cost savings and health outcomes that will be realized by the drivers of this system transformation work has not yet been finalized, so it is not possible at this point to provide estimates of cost savings associated with each driver. However, this work is in process and will be completed prior to Model Testing. As part of the development of this self-evaluation plan, the IME has developed a driver diagram that visually represents the goals of the SIM work, the drivers for transformation, and some information about the types of measures that will be used to measure progress. The driver diagram is provided above.

## **Overview**

IME's self-evaluation plan includes both process and outcome measures, and includes data that will be available for use in CMS's cross-site evaluation and data that are in alignment with national measures. The State intends to contract with a data vendor to develop the data dashboard, provide data analytic support, and assist with reporting. The Iowa Medicaid Enterprise will manage the data vendor.

Several types of process measures will be collected. The first type is process measures related to project implementation. This includes measures of stakeholder engagement, communications, and outreach, as well as measures that track progress toward implementation milestones. The second type of process measures are those that track the process of delivering care, such as provision of preventive services, and care coordination efforts. The third type of process measure is progress toward, and meeting, implementation milestones.

Outcome measures will also be collected and analyzed. This includes measures of Iowa's goals for this project – goals which are in alignment with national goals – including improved quality of care, improved health outcomes, and lower costs. In order to understand the effectiveness of activities and strategies that are part of the SHIP and the transformation work of the SIM, a number of measures will be collected and analyzed. First, data to be collected and analyzed will include measures of the primary drivers of the SIM work, including activities that providers, ACOs, and patients will be

expected to engage in, in order to achieve the goals of the SIM work. Second, measures of the secondary drivers will be collected and analyzed. Third, measures of the ultimate goals of the SIM work will be collected and analyzed, including measures of health outcomes, quality of care, and costs. A primary source for outcome data will be the VIS data, which all ACOs will be required to collect, and to which all ACOs will be held accountable. Additional measures, beyond the VIS, are discussed above.

## **Driver Diagram**

The driver diagram (Figure 48) was provided and discussed in detail above. This visual illustrates the conceptual framework, overall goals, approach, and activities of Iowa's SIM work, as well as the Iowa's approach to measuring and assessing both the process and outcomes of this work.

## **Performance Measures and Data Collection Procedures**

The set of measures that will be collected is described in detail above. As the project evolves, additional measures will be added, and some existing measures may be refined. ACOs may be held accountable to different or additional measures in future years as more is learned through the self-evaluation, CMMI's cross-site evaluation, and the work of the ACOs and providers to improve care and outcomes, and to reduce costs.

Most of the measures to be collected initially are already being collected via claims data, so feasibility of collecting the data is not an issue, with the exception of patient satisfaction data, which may be challenging because of the burden on providers. Continuing to ensure high quality of claims data will be an area of focus, as will conducting high quality analyses.

Another area that will need some work and attention in the immediate future is that of aggregating findings across Medicare and Wellmark. Work is in process to ensure that these data can and will be analyzed in the same ways, and to develop more efficient and transparent processes for the future.

For measures that are not part of claims data, the State will work with the ACOs to develop processes and expectations that meet the needs of the State to monitor and reward quality care, improved health outcomes, and appropriate reductions in costs while not overburdening providers or ACOs. Requirements will be determined by the State and clearly articulated in the ACO contracts and, to the degree possible, as part of the procurement process. Additional data that will be utilized include measures from CAHPS, HEDIS, and BRFSS measures, as discussed elsewhere in this section.

## **Alignment with CMMI Measures**

Many of Iowa's measures of progress in the SIM work are aligned with other national data sets, including Center for Medicare & Medicaid Innovation (CMMI) priority

measures, Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, Behavioral Risk Factor Surveillance System (BRFSS) measures, and/or National Quality Forum measures.

**Table 39: Measures**

Domain	Iowa SIM Measure	CMMI Priority Measure	Indicator/Metric	NQF
Patient/Caregiver Experience	VIS and CAHPS	Yes	CAHPS: Getting Timely Care, Appointments	NQF #5, AHRQ
Patient/Caregiver Experience	VIS and CAHPS	Yes	CAHPS: How Well Your Doctors Communicate	NQF #5, AHRQ
Patient/Caregiver Experience	VIS and CAHPS	Yes	CAHPS: Patients' Rating of Doctor	NQF #5, AHRQ
Patient/Caregiver Experience	VIS and CAHPS	Yes	CAHPS: Access to Specialists	NQF #5, AHRQ
Patient/Caregiver Experience	VIS and CAHPS	Yes	CAHPS: Health Promotion and Education	NQF #5, AHRQ
Patient/Caregiver Experience	VIS and CAHPS	Yes	CAHPS: Shared Decision Making	NQF #5, AHRQ
Patient/Caregiver Experience	VIS and CAHPS	Yes	CAHPS: Health Status/Functional Status	NQF #6, AHRQ
Patient/Caregiver Experience	Under consideration for inclusion as SIM measures specific to children and adolescents	No	CAHPS Group and Clinician Survey, including Medical Home and Chronic Conditions	
Care Coordination/ Patient Safety	VIS: Potentially Preventable Hospital Admissions and Readmissions, and Potential Preventable Emergency Room Visits; considering inclusion of additional measures specific to children/adolescents	Yes	Risk-Standardized, All Condition Readmission; ER visits including focus on children	NQF #TBD CMS
Care Coordination/ Patient Safety	VIS: Admissions related to Chronic Obstructive Pulmonary Disease are part of Potentially Preventable Admissions	Yes	Ambulatory Sensitive Conditions Admissions: Chronic Obstructive Pulmonary Disease (AHRQ Prevention Quality Indicator (PQI) #5)	NQF #275, AHRQ
Care Coordination/ Patient Safety	Admissions related to Congestive	Yes	Ambulatory Sensitive Conditions	NQF #277, AHRQ

Domain	Iowa SIM Measure	CMMI Priority Measure	Indicator/Metric	NQF
<b>Patient Safety</b>	Heart Failure are part of Potentially Preventable Admissions		Admissions: Congestive Heart Failure (AHRQ Prevention Quality Indicator (PQI) #8 )	
<b>Care Coordination/ Patient Safety</b>	Under consideration as a SIM measure of ACO performance	Yes	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility	NQF #97 AMAPCPI/NCQA
<b>Care Coordination/ Patient Safety</b>	Under consideration for inclusion as SIM measures	No	Follow-up after hospitalization for mental illness and after prescribing medications for mental health issues	
<b>Care Coordination/ Patient Safety</b>	Under consideration for inclusion as SIM measures	No	Medical home quality for children and adolescents, i.e., AAP Medical Home Index	
<b>Care Coordination/ Patient Safety</b>	Under consideration for inclusion as SIM measures	No	Effective care coordination for children with special health care needs, including family-to-family support	
<b>Access to Care</b>	Under consideration for inclusion as SIM measures	No	Access to specialty services and medications for children with special health care needs	
Domain	Iowa SIM Measure	CMMI Priority Measure	Indicator/Metric	NQF
<b>Preventive Health</b>	Under consideration as a SIM measure	Yes	Influenza Immunization	NQF #41 AMA-PCPI
<b>Preventive Health</b>	In VIS	Yes	Colorectal Cancer Screening	NQF #34 NCQA
<b>Preventive Health</b>	In VIS	No	Mammography Screening	NQF #31 NCQA
<b>Preventive Health (Tobacco)</b>	Under consideration as a SIM measure	Yes	Tobacco Use Assessment and Tobacco Cessation Intervention	NQF #28 AMA-PCPI
<b>Preventive Health (Tobacco Use)</b>	Under consideration as a SIM measure	Yes	% of adult smokers who attempted to quit smoking (in the last 12 months)	
<b>Preventive Health (Obesity)</b>	Under consideration as a SIM measure	Yes	Adult Weight Screening and Follow-up	NQF #421 CMS

Domain	Iowa SIM Measure	CMMI Priority Measure	Indicator/Metric	NQF
<b>Preventive Health (Obesity)</b>	Under consideration as a SIM measure	Yes	Median intake of fruits and vegetables (times per day) by adults	
<b>Preventive Health (Obesity)</b>	Under consideration as a SIM measure	Yes	% of adults who participated in enough aerobic and muscle strengthening exercise to meet recommended guidelines	
<b>Developmental Screening</b>	Under consideration as a SIM measure	No	Developmental screening and assessment for children and youth	
<b>Mental Health Screening</b>	Under consideration as a SIM measure	No	Screening for exposure to trauma or adverse childhood experiences	
<b>Diabetes</b>	Under consideration as a SIM measure	Yes	% of adults with diabetes who reported receiving a foot exam in the previous year	
<b>Diabetes</b>	Under consideration as a SIM measure	Yes	% of adults with diabetes who reported receiving a dilated eye exam in the previous year	
<b>Diabetes</b>	Under consideration as a SIM measure	Yes	% of adults with diabetes who reported receiving 2 or more A1c tests in the previous year	
<b>Medication Adherence for Hypertension</b>	Under consideration as a SIM measure	Yes	% of adults taking HBP meds	
<b>Alcohol Consumption</b>	Under consideration as a SIM measure	Yes	Number of adults who reported driving after drinking too much in the last 30 days	
<b>Population Health</b>	Under consideration as a SIM measure	No	Pediatric Quality of Life survey or other state data on population health specific to children	

## **Implementation Milestones**

As part of its self-evaluation plan, Iowa has developed implementation milestones. These are discussed in detail in Section 12.

## **Beneficiary Groups**

For most measures identified above, the beneficiary groups for which data will be collected and analyzed by the State include all Medicaid enrollees in Iowa who are enrolled in ACOs. In addition, the State will work with Wellmark to have access to similar analyses on their populations. The State is currently working with Medicare to develop smooth and efficient processes for analyzing and reporting on Medicare data. Most data are already being collected, as they are based in claims data. Other data, such as prevention measures, will require ACOs to collect additional data from the providers they support. Some measures will be limited to specific populations, such as child immunizations or data related to physician visits for people with chronic conditions.

## **Estimate of Targets**

As noted above, preliminary actuarial analyses estimate that a 5% reduction in total costs within four years may be possible utilizing the ACO model, and it is possible that additional savings may be realized when additional data are included, and as ACO activity continues to grow across the state. Additionally, opportunities to reduced costs have been identified through analyses of potentially preventable events. While these analyses are still preliminary, the State has begun to develop some potential goals around these preventable events, as discussed above. The State will track these preventable events and total cost of care via claims data, as discussed below.

## **Frequency of Data Collection and Reporting**

While claims data are collected on an ongoing basis, analyses and reporting will likely be conducted on a quarterly or monthly basis. In addition, the data dashboard will provide the opportunity for additional analyses and reporting to be conducted at any time that it may be necessary. Analyses and reporting on other measures, such as HEDIS measures, measures of care coordination, and client satisfaction measures, will likely be required on at least an annual basis. The State may consider requiring ACOs and providers to administer patient satisfaction surveys more frequently and utilize the data as part of ongoing and continuous quality improvement processes.

## **Responsibility for Data Collection and Reporting**

For measures that rely on claims data, ACOs and providers will be responsible for submitting claims accurately and in a timely fashion. For client satisfaction measures, ACOs will be responsible for ensuring that data are available. These requirements will be clearly defined in the ACO contracts. For other measures, ACOs will be responsible

for providing data. The State or its data vendor will be responsible for reporting, and ensuring that data are available on the data dashboard that will be developed.

### **Analyses and Use of Information for Continuous Improvement**

The State and its data vendor intend to develop a dashboard that will provide timely, actionable data to ACOs and providers, as well as the State and other interested parties, such as the State legislature and other stakeholders. In addition, the State plans to develop a set of standard reports that will be available in a timely fashion to ACOs, providers, and other stakeholders (as appropriate). Providers will be updated monthly in order to facilitate ongoing evaluation. The State and/or its data vendor will be responsible for cleaning claims data, conducting analyses, generating the reports, and ensuring appropriate dissemination. The State and/or its data vendor will ensure that access to the database is limited according to all relevant state and federal regulations.

## **13. Transformation Timeline and Review of Milestones and Opportunities** (Responds to Questions 16 and 17)

The following are the proposed high-level dates. These dates are not finalized and are subject to change but are designed to provide concrete milestones and ensure the ACO model is fully implemented and that system transformation occurs.

### **December 30, 2013: SHIP due to CMS**

The SHIP is a guiding document for the future of health care in Iowa. It provides the vision and goals for the transformed system in Iowa, and is the basis for development and implementation of the ACO model, integration of services across systems, and increased member engagement. The self-evaluation plan, including the implementation milestones outlined in this section, provides the basis for tracking Iowa's progress toward implementation and achieving the outcomes and goals of the SIM work.

### **Winter 2014: Iowa Health and Wellness Plan Implementation and Model Testing Grant Proposal**

The Iowa Health and Wellness Plan will begin providing benefits to enrollees on January 1, 2014, with members attributed to a medical home which might be part of an ACO. Depending on timing, the State will apply for a Model Test Grant and will develop a detailed implementation plan and timeline for the statewide Medicaid ACO program.

## **Spring/Summer 2014: State Issues Request for Information for Prospective ACOs**

After submission of the SHIP, the State will immediately begin development of a request for information (RFI) for prospective ACOs. The RFI will include requests for information about proposed ACO governance, prospective ACOs' intended quality plans, plans for community engagement, commitment to the ACO model, and existing relationships with providers across systems.

This RFI will be released in the Spring or Summer of 2014. The State will assess these responses and use them to help generate the request for proposals.

## **Fall 2014/Winter 2015: State issues Request for Proposals for Prospective ACOs**

In late 2014 or early 2015, the State will issue a full request for proposals (RFP) for prospective ACOs for each region of the State. This RFP will include details about the State's requirements for ACOs, including minimum financial and organizational requirements for participation as an ACO, and requirements related to access to care and quality measurement. Examples of requirements that may be included in the RFP include that a prospective ACO must demonstrate, as part of its proposal, that it:

- understands Iowa's regulatory requirements for its board of directors and has begun to identify prospective organizations and individuals to serve on its board
- understands the minimal requirements it needs to get established, has appointed an executive director and has identified a strategy to recruit necessary personnel
- has developed a set of bylaws including voting rights and procedures and has begun the process of becoming an organization that can legally do business in Iowa

The RFP may also include requirements that prospective ACOs demonstrate, as part of their proposal:

- an understanding of the role of stakeholders (including individuals being served, representatives of community providers and social services agencies) and a commitment to including stakeholders in their development and implementation; a written community engagement plan may be required as part of the ACO contracts
- that they have support from hospitals, primary care providers, behavioral health providers, and providers of long term care supports and services in their region

Additionally, the ACO may be required to demonstrate, as part of its response to the RFP, that it:

- Is committed to and capable of collecting and using data, including data discussed in this SHIP and other data requirements that may be added by the State

- has a robust data strategy and plan for continuing to utilize data for continuous quality improvement

Last, as part of its response to the RFP, a prospective ACO may be required to demonstrate that it:

- understands the importance of care coordination and has a plan to develop a care management strategy
- has developed or will develop a care coordination framework that identifies patients and provides them with appropriate care coordination services

This is not a comprehensive list of the items that may be part of the RFP, but provides examples of what may be included.

During this time period, the State will finalize and issue the RFP, review proposals, and make decisions about ACOs.

### **Winter/Spring 2015: State Selects Regional ACOs**

By Spring of 2015, the State will select regional ACOs and begin implementation planning, including development and finalization of ACO contracts, selection of a data vendor, development of a data dashboard, and recruiting and hiring of additional State staff to manage the ACO contracts and the data vendor contract.

### **January 2016: ACOs Implemented**

By January 2016, ACOs will begin serving all Medicaid members, except for those with Developmental Disabilities, who will initially remain outside of the ACO structure. During this first year of implementation, ACOs will be held accountable for quality measures and total cost of care for physical health care services only (with behavioral health services and LTCSS costs excluded).

### **January 2017: ACOs Held Accountable for Total Cost of Care**

In this second year of implementation of the ACO model, the ACOs will begin to be held accountable for total costs of care, including responsibility for LTCSS and BH services.

### **State Fiscal Year 2020: ACOs are Fully Capitated**

It is the State's plan that the ACOs will be fully capitated as of State Fiscal Year 2020. The table below provides details about the tasks, timing, and triggers associated with this goal.

**Table 40: Proposed Triggers and Timing**

Proposed Triggers and Timing for Increasing Total Cost of Care (TCOC) Accountability			
Phase 1 – Wellness Plan ACOs <i>Start 1/1/2014</i>	Phase 2 – Regional Medicaid ACOs <i>Start Early 2016</i>	Phase 3.a – Add in BH Services to TCOC <i>Start Early 2017</i>	Phase 3.b – Add in LTCSS to TCOC <i>Start Early 2018</i>
Proposed readiness requirements for ACO receiving increased shared savings			
	Trigger: ACO Proposals show readiness	Trigger: ACOs VIS measures around BH show readiness to coordinate these services	Trigger: ACOs VIS measures around LTCSS show readiness to coordinate these services
<ul style="list-style-type: none"> <li>Wellness Plan members have access to primary care</li> <li>Member outreach and engagement strategies</li> <li>Incentives align with members' health behaviors</li> <li>Incentives for system improvement through Value Index Score (VIS) quality measurements</li> <li><i>No shared savings or downside risk initially (will be added in subsequent years)</i></li> </ul>	<ul style="list-style-type: none"> <li>Well defined care coordination program</li> <li>Community relationships with traditional and non-traditional providers established</li> <li><b>ACO</b> payment structure</li> <li>Shared savings triggered by VIS and TCOC outcomes</li> <li>ACOs choice:3 risk levels</li> <li>Up and down side risk</li> <li>Some BH and some LTCSS expenditures not included in TCOC calculation</li> </ul>	<ul style="list-style-type: none"> <li>Established IHH capacity to serve Serious &amp; Persistent Mental Ill (SPMI) population</li> <li>Established formal relationships with IHH providers</li> <li>Refined care coordination program to account for complexities of population with high Behavioral Health needs</li> </ul>	<ul style="list-style-type: none"> <li>Established formal relationships with all Long Term Care (LTC) provider types, including but not limited to those serving individuals with Intellectual Disabilities</li> <li>Demonstrates data sharing capabilities with LTC providers</li> <li>Demonstrated Balancing Incentive Payment Program (BIPP) with increased percentage of home and community based (HCBS) spending</li> <li>Refined care coordination program to account for complexities of populations</li> </ul>

## 14. Policy, Regulatory and Legislative Changes Necessary (Responds to Questions 18 and 19)

### Statutory Changes

In June of 2013, when Governor Branstad signed the Iowa Health and Wellness Plan legislation, the State officially set in motion the statutory changes that will be required to develop the ACO model being proposed. The part of the legislation that is getting the most attention is the approach to providing health care for adults with incomes below 133% FPL who are not eligible for other Medicaid coverage. However, this is only one

facet of the law; the legislation also authorizes delivery and payment system reforms including expanded use of medical homes and ACOs.

Specifically, to support the enhancement of collaboration and care coordination, the legislation requires that the DHS develop a mechanism for primary medical providers, medical homes, and participating ACOs to jointly facilitate member care coordination. Iowa Health and Wellness providers will be reimbursed for providing care coordination services; this is also a component of the statewide Medicaid ACO model described in this SHIP. The emphasis on whole person orientation that requires that the personal provider be responsible for providing for all of a patient's health-related needs or taking responsibility for appropriately arranging for health-related services provided by other qualified health care professionals and providers of medical and nonmedical health-related services is clearly articulated and is also fundamental to the success of the statewide Medicaid ACO model. The ACOs are required to incorporate the medical home as a foundation and to emphasize whole-person orientation and coordination and integration of both clinical services and nonclinical community and social supports that address social determinants of health. The legislation also furthers the State's goal of developing quality performance standards that consider those utilized by other ACO models.

The legislation authorizes the use of payment models that include but are not limited to risk sharing, including both shared savings and shared costs, between the State and the participating ACO, and bonus payments for improved quality. These shared savings commence during the initial year of the contract; there must be quality metrics in place within three years of the initial year of the contract; and the ACOs must participate in risk sharing within five years of the initial year of the contract. Again, the foundation for expansion to statewide ACO models has been created.

To implement the provisions, the DHS is already developing procedures for ACOs that emerge through local markets and is negotiating contracts with the ACOs that will ensure the coordination and management of the health of attributed members, produce quality health care outcomes, and control overall cost. The contracts also establish a baseline of ACO accountability based on quality performance and total cost-of-care metrics. They will also serve as a starting point for the larger statewide ACO contracts to be developed.

Finally, the legislation establishes a framework for exchange of member health information as provided by rule to facilitate coordination and management of members' health, quality health care outcomes, and containment of and reduction in costs. The DHS is required to provide the health care claims data of attributed members to a member's participating accountable care organization on a timeframe established by rule of the department.

Embedded in the new law is language that calls for the expansion of the medical homes to the greatest extent possible to children, other adults, and Medicare and dually eligible Medicare and Medicaid recipients (if approved by CMS). January 1, 2015, is the target

date for this. More immediately, the law requires that any integrated care model implemented on or after July 1, 2013, that delivers health care to medical assistance program recipients shall incorporate medical homes as its foundation. Finally, there is a requirement that there is cross-departmental and agency collaboration to allow state employees to utilize the medical home system and with insurers and self-insured companies, if requested, to make the medical home system available to individuals with private health care coverage. This collaboration will further the multi-payer, incentive-aligned SIM model.

On December 5, 2013, the DHS submitted its report to the .Advisory Council and indicated they did not have recommendations for proposed legislation at the time of report preparation. Moving forward, the DHS, the Governor's office and members of the Legislature will assess and monitor the progress of the Iowa Health and Wellness Plan and consider whether the law requires amending in order for the State to meet the goals articulated in the Iowa Health and Wellness Plan as well as those that have been articulated in this SHIP.

### **Regulatory Changes**

To implement the Iowa Health and Wellness plan the DHS has been drafting rules and developing new policies and procedures. To date the DHS has not identified specific and necessary regulatory changes that will be required for the statewide Medicaid ACO model but will monitor whether the Iowa Health and Wellness plan regulations are supporting the State in meeting program objectives. The DHS will use the lessons learned from the development of Iowa Health and Wellness plan regulations and policies and apply them to future rules and policies that will be developed for the SIM model.

### **Ongoing Collaboration**

In addition to articulating delivery system and payment reform activities, the new law created avenues for continued collaboration and discussions between the Executive and Legislative branches of State government. There is a new Advisory Council for State Innovation Models Initiative (Advisory Council) and a Legislative Interim Committee on Integrated Care (Interim Committee). The legislative advisory council is tasked with guiding the development of the design model and implementation plan for the SIM; providing oversight of activities; and making recommendations regarding integrated care models implementation strategies. Advisory council membership consists of members of the General Assembly, members of the Governor's advisory committee who developed the SIM grant proposal and this SHIP, and representatives of consumers and health care providers, appointed to ensure that the process provides ample opportunity for the variety of stakeholders to participate. The Interim Committee was created for the 2013 legislative interim and includes at least ten members of the General Assembly and may include appointed members of the public who represent consumers, health care providers, hospitals and health systems, and other entities with interest or expertise related to integrated care models. The interim committee was

responsible for reviewing and making recommendations; reviewing integrated care models in other states; reviewing the progress of medical homes; reviewing existing and proposed integrated care models in the state to determine the opportunities for expansion or replication; and addressing the issues relative to integrated care models including those relating to consumer protection; payment and financing issues; organizational, management, and governing structures; performance standards; patient attribution or assignment models; health information exchange, data reporting, and infrastructure standards; and regulatory issues. The Interim Committee held a hearing on November 19-20, 2013 and will present a summary of its review and recommendations in a report to the 2014 session of the general assembly. The agenda and materials from this hearing are available on-line:

<https://www.legis.iowa.gov/committees/committee?endYear=2013&groupID=19051>

The Iowa Health and Wellness Plan is an important new law because of the benefits it will provide to Iowa health care consumers who had been uninsured. For providers, it offers opportunities to improve the care provided and to be reimbursed for the value and quality of care they provide. For the State as a whole an additional benefit is that it demonstrates again Iowans desire and ability to work together across party lines to meet important goals.

### **Federal Approval**

The federal approval process is an important component of operationalizing the new model. Early in the design process, the State will assess the type of regulatory authority that will be needed to implement the ACO model. If an 1115 Demonstration Waiver is needed, the State will begin the process at least 12 months prior to scheduled implementation. The process for approval of a State Plan Amendment (SPA) is less time-intensive but the State will also initiate this early to ensure approval is received well in advance of program go-live. It is possible that the statewide ACO model will require both an 1115 Demonstration Waiver and a SPA.

Over the past six months, the State has been working closely with CMS to receive approval for the Iowa Health and Wellness Plan. Moving forward, the State plans to continue these conversations to determine the best approach to developing a statewide Medicaid ACO model that meets both State and CMS goals and objectives. In preparation for this collaboration and as initial steps, the State will review and analyze the recent guidance CMS has issued on developing integrated care models with the goal of achieving better care, better health, and reduced expenditures in Medicaid programs. As more states take this approach, the State looks forward to learning about options and solutions as well as potential barriers.

# Appendices

## Appendix A: Acronym List

ACA – Accountable Care Act

ACO – Accountable Care Organization

AHRQ – Agency for Healthcare Research and Quality

BH – Behavioral Health

BHO – Behavioral Health Organization

BIPP – Balancing Incentives Payment Program

BRFSS - Behavioral Risk Factor Surveillance System

CAH – Critical Access Hospital

CAHPS – Consumer Assessment of Health Plan Study

CCD – Continuity of Care Document

CHIP – Children’s Health Insurance Population

CMHC – Correctional Managed Health Care

CMMI - Center for Medicare & Medicaid Innovation

COM- College of Osteopathic Medicine

CPOE – Computerized Physician Order Entry

CPRS – Computerized Patient Record System

CRG – Clinical Risk Group

CRISP - University of Iowa Carver College of Medicine’s Rural Iowa Scholars Program

DMU – Des Moines University

DRG – Diagnosis-Related Groups

EHR – Electronic Health Records

ESI – Employer Sponsored Insurance

FFS – Fee-for-service

FMAP – Federal Member Assistance Percentage

FPL – Federal Poverty Level

FQHC – Federally Qualified Health Centers

H2O- Health and Happy Outdoors

HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems

HCBS - Home and Community Based Services

HEDIS – Healthcare Effectiveness Data and Information Set

HEN – Hospital Engagement Networks

HIE- Health Information Exchange

HIPP – Health Insurance Premium Payment

HISP – Health Information Service Provider

HIT – Health Information Technology

HIT REC – Health Information Technology Regional Extension Center

HRA – Health Responsibility Account

ICF/MR – Intermediate Care Facilities for individuals with Mental Retardation

IDPH – Iowa Department of Public Health

IFMC – Iowa Foundation for Medical Care

IHC – Iowan Healthcare Collaborative

IHH – Integrated Health Homes

IHIN – Iowa Health Information Network	PPV- Potentially Preventable ERD/ER Visits
IME – Iowa Medicaid Enterprise	PQI – Preventative Quality Indicators
JCAHO – Joint Commission on Accreditation of Healthcare Organizations	QHP – Qualified Health Plan
LCTSS – Long Term Care Supports and Services	RBRVS- Resource-based Relative Value Scale
LUPA – Low Utilization Payment Adjustment	REC – Regional Extension Centers
MHDS – Mental Health and Disability Services (MHDS) Redesign	RHC – Rural Health Clinic
MHN – Mercy Health Network	RMEP – Rural Medicine Educational Pathway
MSSP – Medicare Shared Savings Plan	RPMS – Resource and Patient Management Systems
MVM – Medicaid Value Management	SED – Serious Emotional Disturbance
NCQA- National Committee for Quality Assurance	SIM – State Innovation Model
NeHII – Nebraska’s Health Information Initiative	SHIP – State Healthcare Innovation Plan
OMB – Office of Management and Budget	SMHP – State Medicaid HIT Plan
OOP – Out-of-Pocket	SMI – Serious Mental Illness
OSCEP – Office of Statewide Clinical Education Programs	SOP – Iowa Strategic and Operations Plan
PCMH – Patient-centered Medical Home	SPMI – Severe and Persistent Mental Illness
PCP- Primary Care Practitioner	TANF – Temporary Assistance for Needy Families
PKPY – Per Thousand People per Year	TCOC – Total Cost of Care Calculations
PMIC – Psychiatric Medical Institutions for Children	UIHC – University of Iowa Hospital and Clinics
PMPM – Per Member per Month	VBP – Value-Based Purchasing
PPA – Potentially Preventable Admissions	VHA – Veteran Health Administration
PPE – Potentially Preventable Events	VIS – (Treo) Value Index Scores
PPR- Potentially Preventable Readmissions	

## Appendix B: Methodology

Treo Solutions received four years of Medicaid claims data from the Iowa Medicaid Enterprise (IME) for their members. These claims included standard fee for service (FFS) claims as well as Behavioral Health Encounters. Treo processed these claims in order to provide an enhanced risk adjusted data set designed to provide meaningful analytics to IME. The following describes the methodology and approach.

Treo Solutions received claims data for 2009, 2010, 2011, and 2012. The number of unduplicated Medicaid enrollees for whom claims were received varied from year to year, with a low of 676,894 in 2009 and a high of 796,223 in 2012. Table B.1 provides more details about the number of Medicaid enrollees per year.

**Table B.1: Medicaid Enrollees and Claims Data, by Year, 2009-2012**

Year	Medicaid Enrollees
2009	676,894
2010	711,699
2011	755,250
2012	796,223

### Data Validation

After Treo received the claims from IME, two validation checks were performed for each feed of claims data. The first validation check was a Contents Description Report and Treo's summary of data completeness. The second was a Source Data Integrity Check (SDIC), which included more than 60 tests examining items such as matching bill types, duplicates, and referential integrity. Both of these reports were shared with IME through an SDIC Review.

### Contents Description Report

The Contents Description report is a descriptive statistical report that indicates the level of completeness of client data. This report contains two sections. The first section shows for each column of data in a table: the percentage filled, data typing review, maximum, and minimum values. Numeric columns are also totaled. The second section lists the top 20 most common values for each column. This report was run on each of the claims data sets.

### Source Data Integrity Checks and Report

Source Data Integrity Checks (SDICs) are a set of in-depth reviews that look for specific conditions known to affect the quality of the data, and uncover problems or issues with the data that may not be readily apparent. The SDICs were run on each of the claims data sets and problems with the data were identified and resolved.

### Referential Integrity

Next, a complete referential integrity of the transmission was performed. In this series of tests, claim header and line files are checked to ensure that lines with associated headers do not exist. Every claim header row must contain at least one claim line. Every

Facility ID contained in claims must be present in the Facility table. If Member and Employer tables are present, then each Member ID and Employer ID in the claim files must be present in Member and Employer tables. These tests were run for each of the claims data sets.

### **Aggregation**

Next, it was important to define the rules to be used for all aggregation and analysis. These rules help to ensure that the key performance indicators required for monitoring and reporting are of high quality and integrity. These rules include the identification of distinct member categories. The following population groups (and their associated claims) were identified in the analysis.

- Long Term Care – provided by IME as a member based flag indicating members utilizing institutionalized LTC services
- Waiver – provided by IME as a member based flag indicating members utilizing home and community based services
- Medicare Dual Eligible – provided by IME as a member based flag
- HMO – provided by IME as a member based flag indicating members by member program
- Presumptive Eligibility – provided by IME as a member based flag by Aid Type
- Iowa Family Planning Network – provided by IME as a member based flag indicating member by Aid Type
- IowaCare – provided by IME as a member based flag indicating members by Aid Type
- Foster Care – provided by IME as a member based flag indicating members by Aid Type
- SPMI – SPMI population was identified using a Treo mental health indicator. (The mental health indicator to determine SPMI considers both mental health related diseases as well as substance abuse related diseases. Below is a list of conditions represented by the mental health indicator: Schizophrenia; Eating Disorder; Bipolar Disorder; Conduct, Impulse Control, and Other Disruptive Behavior Disorders; Depressive and Other Psychoses; Major Personality Disorders; Chronic Mental Health Diagnoses – Moderate; Cocaine Abuse; Opioid Abuse; Chronic Alcohol Abuse; Other Significant Drug Abuse; Drug Abuse – Cannabis/Other.)

Using these flags, it was possible to group members by these categories. Table 2 provides details about the number of Medicaid enrollees in Iowa who, in 2012, met the criteria for each category.

**Table B.2: Medicaid Enrollees by Category, 2012**

<b>Population Tag</b>	<b>Medicaid Enrollees</b>
Long Term Care (IME Member Management)	9,379
Medicaid (Member Management)	514,434
Medicare Dual Eligible (IME Member Management)	72,106
Waiver (IME Member Management)	21,813
SPMI (Treo Defined, Non exclusive)	51,384
HMO (IME Member Program)	12,650
Iowa Family Planning Network (IME Aid Group)	54,515
Iowa Care (IME Aid Group)	94,865
Foster Care (IME Aid Group)	652
Other (Remaining Aid groups Excluded)	15,809

It is also in this phase that the necessary unique identifiers for providers and members were calculated, and a number of master indices were built so that total cost, quality, and utilization could be calculated to the person categorically.

### **Managing Patient/Member Identities**

A Master Patient Index was created to identify each unique patient in the data set. Each master patient record includes data elements critical to subsequent matching efforts and reporting needs. Additionally, the enrollee record included a date span of enrollment and eligibility with a payer along with the assigned or attributed Primary Care Provider (PCP) and Clinical Risk Group (CRG) score for that date span.

### **Attribution**

Next, enrollees were “attributed” to a provider, so that analyses to determine existing service delivery and referral patterns could be conducted. The IME sent Treo the assigned PCP for a number of members, many of whom selected their PCP upon enrollment. In these cases, that selected relationship was retained. For those members not assigned to a PCP by IME, Treo used the following methodology to attribute them to a PCP. The attribution was based on counting unique Evaluation and Management (E & M) visits to PCP eligible physicians within a physician group. The member was assigned to the physician group with the highest number of unique visits. Once the physician group was assigned, the same process was used to determine the individual PCP within the group. Attribution was calculated using the most recent 12 months of claims history for an enrollee in order to attribute. If attribution could not be determined based on the most recent 12 months, an additional 12 month look back was used.

### **Data Enhancement**

Once the data were processed and aggregated as described above, and the patients attributed, the data were ready for reporting and analysis. All of the inpatient (IP) and

outpatient (OP) claims were processed through two separate 3M™ Health Information Systems (HIS) groupers. IP claims were processed through the 3M™ HIS All Patient Refined-Diagnosis Related Groups (APR-DRG) grouper, and outpatient claims were processed through the 3M™ HIS Enhanced Ambulatory Patient Groups (EAPG) grouper. Both groupers utilize the diagnoses codes, along with the procedural codes submitted for each incident of service – along with the patient’s CRG risk score – to identify both an observed and an expected cost for each service. By applying the logic inherent in these groupers to these claims, the data were arrayed for comparative analytics to allow for a comparison of actual values to “expected” values. Expected values are meaningful because they show the variation in performance metrics from the network average. From this, Total Cost of Care was calculated for all enrollees including medical and pharmacy costs. The risk adjustment of total cost of care took into account the enrollees’ clinical risk category, age and gender. The risk adjusted expected value was aggregated for each enrollee to account for expected expenses of the entire population.

## **Risk Adjustment**

Two different methods of risk adjustments were applied for this analysis.

1. Member-based: The 3M™ HIS Clinical Risk Group tool was used to create clinical risk scores for population risk adjustment and analytics. CRGs form the foundation of a population classification system that helps to predict the amount and type of healthcare services that individuals should have used in the past [retrospective] or can be expected to use in the future [prospective]. CRGs help to manage financial risk and ensure the delivery of quality healthcare to individuals based on their needs and health status. CRGs are the basis of a categorical clinical model that uses standard claims data—including inpatient, outpatient, physician, and pharmacy data—to assign each patient to a single mutually exclusive risk category. Severity adjustment is part of the model. CRGs include specific severity of illness subclasses for all chronic illnesses, recognizing that although individuals may have the same condition, they may have different levels of severity. CRGs use standard claims data.
2. Inpatient/Outpatient Services: For purposes of analysis, and risk stratification of the utilized services across all facilities, all of the inpatient (IP) and outpatient (OP) claims were processed through two separate 3M™ HIS groupers. IP claims were processed through the 3M™ HIS APR-DRG grouper, and OP claims were processed through the 3M™ HIS EAPG grouper. Both groupers include levels of service utilizing the diagnoses codes, along with the procedural codes submitted for each incident of service to identify both an observed and an expected cost for each service.

## Appendix C: Steering Committee Membership

Steering Committee Members
Michael Boussetot, Governor's Office
Ed Brown, Iowa Clinic
Doug Cropper, Genesis Health System
Angela Walker Franklin, Des Moines University
Nick Gerhart, Iowa Division of Insurance
Laura Jackson, Wellmark Blue Cross & Blue Shield
Jody Jenner, Broadlows Medical Center
Clare Kelly, Iowa Medical Society
Bill Leaver, Unity Point
Marianette Miller-Meeks, Iowa Department of Public Health
Charles Palmer, Iowa Department of Human Services
Dr. Jean Robillard, University of Iowa Hospitals and Clinics
Dave Vellinga, Mercy Health System
Jennifer Vermeer, Iowa Medical Enterprise
Sam Wallace

## Appendix D: Workgroup Members

Member Engagement
Chair: Chris Atchison, University of Iowa Hospitals & Clinics
Steve Flood, Holmes Murphy
Pat Giorgio, Evergreen Estates
Jay Hansen, Prairie Ridge Addiction
Lance Horbach, Stakeholder
Lanett Kane, People's Federall Qualified Health Center
Kari Prescott, Webster County Public Health
Lana Ross, Community Addiction Association
Catherine Simmons, Unity Point
Ann Williamson, University of Iowa Hospitals & Clinics

Metrics and Contracting
Chair: Tom Evans, Iowa Health Care Collaborative
Dr. Theresa Brennan, University of Iowa Hospitals & Clinics
Charlie Bruner, Child & Family Policy Center
Stacey Cyphert, University of Iowa Hospitals & Clinics
Chris Esperson, Primary Health Care
Michael Fay, Wellmark Blue Cross & Blue Shield
Robb Gardner, Henry County Health Center
Pamela Halvorson, Trinity/ Unity Point
Kris Hansen, Western Home Communities
Mike Isaacson, Hawkeye Valley Area Agency on Aging
Dr. Andrea McGuire, Meridian Health Plan
Bruce Meisinger, Black Hawk County Public Health
Noreen O'Shea, Mercy Sioux City & Community Health Clinics
Paul Pietzsch, Health Buyers Alliance
Patrick Schmitz, Plains Areas Community Mental Health Center
Mikki Steir, Broadlawns Medical Center
Dr. David Swieskowski, Mercy Medical Center
Debra Waldron, Child Health Specialty Clinics

## Mental Health and Substance Abuse

Chair: Rick Shults, Department of Human Services

Teresa Bomhoff, Consumer

Jason Haglund, Youth & Shelter Services, Inc.

Jan Heikes, County Social Services

Earl Kelly, Eyerly Ball

Dr. Alison Lynch, University of Iowa Hospitals & Clinics

Dr. Vincent Mandracchia, Broawdlawns Medical Center

Maria Montanaro, Magellan Behavioral Health Services of Iowa

Mary O'Neil, Heartland Family Services

Anne Star, Orchard Place

Kathy Stone, Iowa Department of Public Health

## Long Term Care

Chair: Donna Harvey, Iowa Department on Aging

Becky Blum, Iowa Insurance Division

Bery Engebretsen, Primary Health Care

Becky Harker, Iowa Developmental Disabilities Council

Steve Hess, Immanuel Pathways

Doug Johnson, Hawkeye Care Centers

Barb Morrison, Southwest 8 Area Agency on Aging

Greg Nelson, Norheat Iowa Family Education Foundation

Meg Nugent, Iowa Health Care Collaborative

Monique Reese, Iowa Health Home Care/ Unity Point

Rod Roberts, Iowa Department of Inspections and Appeals

Julie Shilling, Lee County Public Health

Julie Schwarting, B&D Services

Dr. Lloyd Vanderwaak, ChildServe

Kimberly Weber, Iowa Home Care

## Notes

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<sup>1</sup> NORC analysis of National Association of Insurance Commissioners (NAIC) 2011 data. Included in the Benchmark State Profile Report for Iowa.

<sup>2</sup> National Health Policy Forum. National Spending for Long-Term Services and Supports (LTCSS), 2011. February, 2013.

<sup>3</sup>Feinberg, *et al.*, Valuing the Invaluable: 2011 Update The Growing Contributions and Costs for Family Caregivers, *AARP Public Policy Institute*, 2011

<sup>4</sup> Feinberg, *et al.*, Valuing the Invaluable: 2011 Update The Growing Contributions and Costs for Family Caregivers, *AARP Public Policy Institute*, 2011

<sup>5</sup> Centers for Disease Control and Prevention. Public Health in the Age of Health Care Reform. Oct 2012

[http://www.cdc.gov/pcd/issues/2012/12\\_0151.htm](http://www.cdc.gov/pcd/issues/2012/12_0151.htm)

<sup>6</sup> U.S. Census Bureau; American Community Survey. (2011). *Iowa State Quick Facts* .

<sup>7</sup> U.S. Census Bureau; American Community Survey. (2011). *Iowa State Quick Facts*

<sup>8</sup> National Survey of Children with Special Health Care Needs. 2009-2010 data. The federal Maternal and Child Health Bureau defines children with special health care needs as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

<sup>9</sup> Morello-Frosch, R., Zuk, M., Jerrett, M., Shamasunder, B., & Kyle, A.D. (2011). Understanding The Cumulative Impacts Of Inequalities In Environmental Health: Implications For Policy. *Health Affairs*, 30(5), 879-887.

<sup>10</sup> Agency for Healthcare Research and Quality. 2011 National Healthcare Disparities Report. Rockville, MD: US Department of Health and Human Services. AHRQ publication no. 12-0006; 2012. Retrieved from <http://www.ahrq.gov/qual/nhdr11/nhdr11.pdf>.

<sup>11</sup> Rossen, L.M. and Schoendorf, K.C. (2012). Measuring health disparities: trends in racial-ethnic and socioeconomic disparities in obesity among 2- to 18-year old youth in the United States, 2001–2010. *Annals of Epidemiology*, 22 (10), 698-704.

<sup>12</sup> Yao, L. & Robert, S.A. (2008). The Contributions of Race, Individual Socioeconomic Status, and Neighborhood Socioeconomic Context on the Self-Rated Health Trajectories and Mortality of Older Adults. *Research on Aging*, 30(2), 251-273.

<sup>13</sup> Kaiser Family Foundation <http://kff.org/other/state-indicator/distribution-by-fpl/>

<sup>14</sup> Estimates are point-in-time and do not count anyone who was enrolled at any point in the year. Point-in-time estimates are lower than counts of anyone enrolled throughout the year. The Medicaid rate includes those who are dually eligible for Medicare and Medicaid; they are not counted in the Medicare rate. Other public includes military and VA benefits. Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2011 and 2012 Current Population Survey (CPS: Annual Social and Economic Supplements). Available at <http://kff.org/other/state-indicator/total-population/>

<sup>15</sup> State Health Access Data Assistance Center (2012) pg. 10

<sup>16</sup> Kids Count Data Center. "Children in Poverty" 2012.

<http://datacenter.kidscount.org/data/tables/43-children-in-poverty#detailed/1/any/false/868,867,133,38,35/any/321,322>

<sup>17</sup> U.S. Census Bureau. American Community Survey. Data Profile. Selected Economic Characteristics.

<sup>18</sup> National Center for Poverty in Children. Columbia University, Mailman School of Public Health. Iowa [http://www.nccp.org/profiles/IA\\_profile\\_6.html](http://www.nccp.org/profiles/IA_profile_6.html)

<sup>19</sup> Urban Institute estimates based on ACS-HIPSM, prepared for the Kaiser Commission on Medicaid and the Uninsured, 2013.

<sup>20</sup> These percentages differ slightly from those reported later in this SHIP. The above data are based on analysis of national survey data and are used here to allow for comparisons to the national average. The numbers and percentages reported later are based on actual enrollment as analyzed by IME staff. They are the more accurate percentages but to facilitate comparisons with national averages the survey data have been used here.

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- <sup>21</sup> The Children's Health Insurance Program (*hawk---*) Impact of the ACA and Health System Change on the Iowa Safety Net Peter C. Damiano Suzanne E. Bentler Astha Singhal Peter Schumacher. The University of Iowa Public Policy Center. October 1, 2013
- <sup>22</sup> Department of Human Services. The Children's Health Insurance Program. [http://www.dhs.state.ia.us/uploads/Children\\_Health\\_Insurance\\_Program\\_Narrative.pdf](http://www.dhs.state.ia.us/uploads/Children_Health_Insurance_Program_Narrative.pdf)
- <sup>23</sup> Commonwealth Fund. (2009). *Scorecard on Health System Performance*. Commonwealth Fund.
- <sup>24</sup> Community Health Needs Assessment. page 17.
- <sup>25</sup> F as in Fat. Interactive: Adult Obesity in the United States, 1990-2012. <http://fasinfat.org/adult-obesity/>
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- <sup>46</sup> Health Indicators Warehouse. Demographic Indicators. <http://healthindicators.gov/Indicators/Selection>
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- <sup>65</sup> NovaRest Report for the Iowa Insurance Division in Support of the Annual Report to the Iowa Governor and to the Iowa Legislature." November 2012, page 3.
- <sup>66</sup> "Improve Iowans' Health Status," Iowa Department of Human Services, page 3-6.
- <sup>67</sup> State Health Access Data Assistance Center , 2012 pg. 10
- <sup>68</sup> Improve Iowans' Health Status, p.3.
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- <sup>71</sup> Iowa Department of Human Services. "Improve Iowans' Health Status,"
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- <sup>73</sup> Iowa Department of Human Services. "Improve Iowans' Health Status,"
- <sup>74</sup> Iowa Department of Human Services "Improve Iowans' Health Status," pages 8-9.
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- <sup>96</sup> More information on the Iowa HIT REC can be found on their website: <http://www.telligenhitrec.org/>
- <sup>97</sup> This question was presented during Stage 1 and did not take into account plans for Stage 2 certified systems.
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- <sup>120</sup> Additional information is available at <http://www.bluezonesproject.com/>.
- <sup>121</sup> Healthiest State Initiative, "Programs: Blue Zones Project™" <http://www.iowahealthieststate.com/blue-zones>.